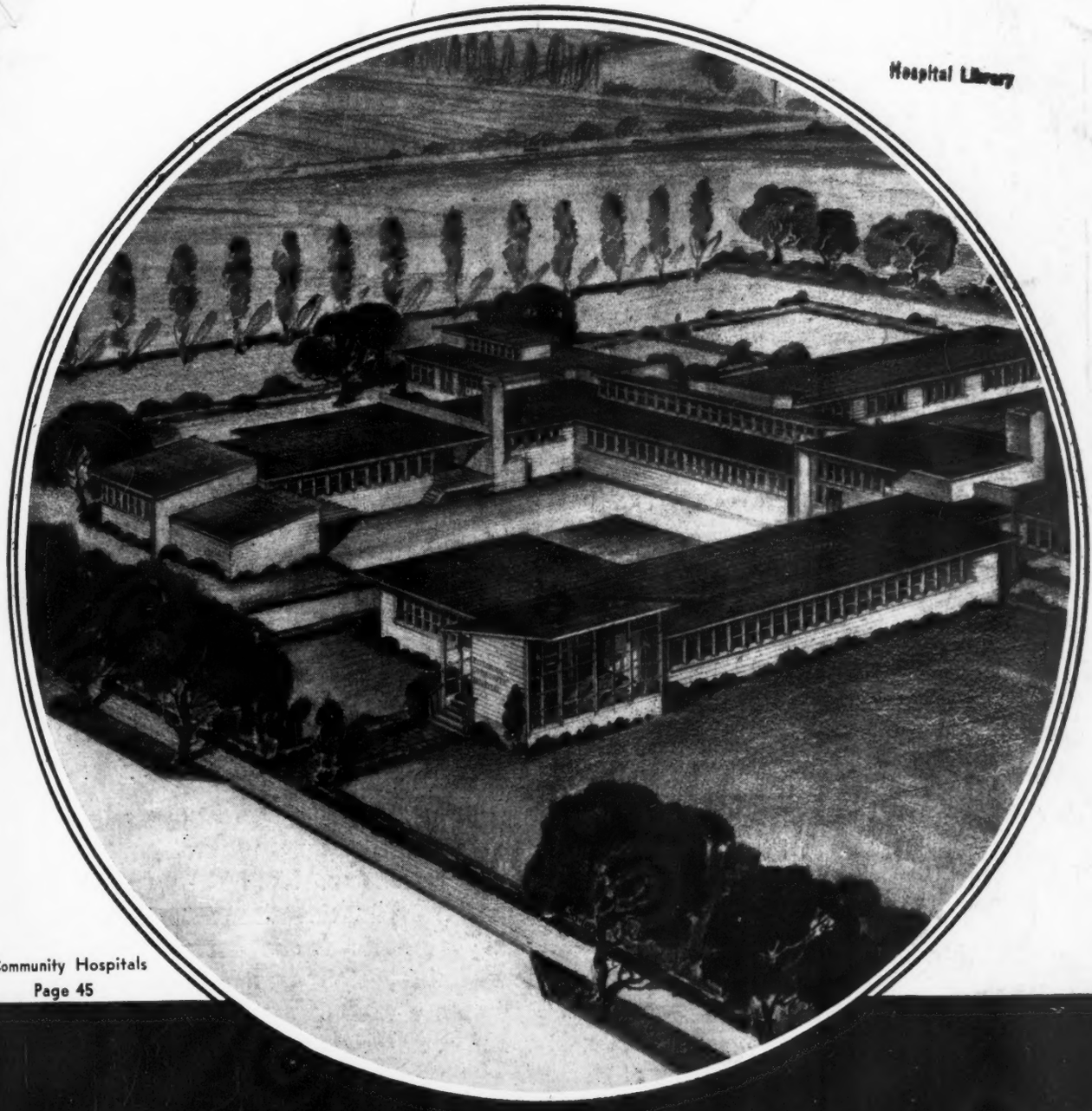

Community Hospitals
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The MODERN HOSPITAL

VOLUME AUGUST 1944 NUMBER

SEISMOGRAPH . . . the instrument that measures and records the magnitude and direction of minute vibrations of the earth's crust. It is of such sensitive construction that records can be made with it of tremors originating from earthquakes on the other side of the world!

Perfection IN ITS FIELD

Pioneer earthquake studies by John Milne, British scientist, led to the development of the delicate instrument which was the precursor of the modern seismograph . . . the most perfect device known to physicists for the recording of subterranean disturbances. SKLAR, too, in order that it might produce surgical instruments as nearly perfect as surgeons could wish for, has always pioneered in research —being among the first in the industry to use chromium . . . and one of the first to see the possibilities in stainless steel. It is this forward-looking spirit . . . . combined with the refusal to compromise with quality of materials or workmanship . . . . which has won for the J. Sklar Manufacturing Company leadership in a highly specialized industry . . . . *Sold only through accredited surgical instrument distributors.*

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A Catalog of Sklar Stainless Steel Instruments will be provided on request.

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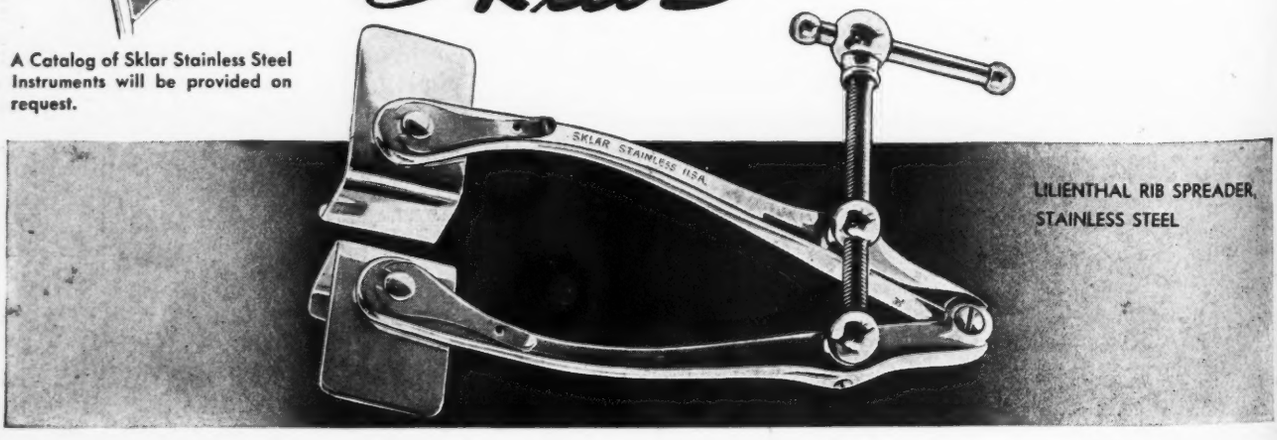

LILIENTHAL RIB SPREADER, STAINLESS STEEL

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THE ROVING REPORTER

After 6000 Years

Finally they got the donated press mounted and rolling and in June your Roving Reporter's favorite house organ appeared for the first time in printed form. The *Star,* "radiating the light of truth on Hansen's Disease," is the patients' own paper at the U. S. Marine Hospital, National Leprosarium, Carville, La. You may remember the reference to the work of the blind editor-patient, Stanley Stein, on this page last February.

The U. S. Public Health Service's recreational aid at Carville, Grover Thames, is in charge of journalistic activity and interested patients contribute news, instructive or amusing articles and poems to the *Star* through him.

How successful the *Star's* campaign is in getting the term "Hansen's Disease" substituted for the falsely feared "leprosy" may be seen through the fact that the latest edition of Dorland's Medical Dictionary so lists it under "disease." Another landmark in the growing campaign against leprophobia is the fact that the board of health of New York State does not include the disease under any name in its list of reportable communicable diseases.

Dr. G. H. Faget, medical officer in charge at Carville, reports in his salute to the *Star* in its new dress that promin, diasone and other promin-like derivatives are being found useful in combating certain complications of the disease and even in arresting its progress. Apparently it is too soon to make any strong claims for these newly developed drugs.

If you would like to subscribe for this little monthly magazine and feel yourself part of a crusade to aid the people who are detained there for a disease that the medical world classes as only "feebly communicable" because its method of transmission is still unsolved, it costs only $1. After reading one issue, you will be talking Hansen's Disease to all of your friends and will be joining the campaign against the ill-founded dread of the disorder that has endured for 6000 years.

Any Odd Shoes Today?

You'll want to know about the National Odd Shoe Exchange of St. Louis. It isn't the only odd shoe exchange by any means but none of these exchanges has been well publicized and the persons who really need their services rarely know about them. We're boosting the St. Louis exchange for the simple reason that Ruth C. Rubin, O.T.R., the director, has asked us to.

Any hospital person knows men and women and children who, because of disease or injury, must wear shoes of different sizes, as they know others who, because of amputation, wear one shoe only. To get one properly fitting pair the former must buy two pairs of shoes and the latter, two shoes when he needs but one. Not only does this involve a double expense but, as Miss Rubin points out, there is concern about the mismates going to waste.

An odd shoe exchange keeps a card file of persons wearing two sizes with the exact measurements of both feet. When two persons who might be able to exchange shoes with each other are found they are notified. Further arrangements regarding collecting the shoes, as well as the style of future pairs, is worked out between the new-found partners. The whole project is a free service provided persons who write in to the exchange.

"I feel that the serious increase of postwar casualties will give my organization even greater scope of service after the war," Miss Rubin declares. "We must be prepared to meet the needs of these men and help them all we possibly can."

Take down the address of this exchange. It's National Odd Shoe Exchange, 6267 Clemens Avenue, St. Louis 5.

For the Amazement of All

The men volunteers of Albany Hospital, Albany, N. Y., gave a party on a recent Monday evening but they did not let their jobs go unattended. They called on medical students to take over on the wards and the students jumped at the chance for the volunteers promised to undertake some of their hospital responsibilities during the next examination week.

The party was to welcome new volunteers enlisted during the recent recruiting drive put on by the men's volunteer division. The newcomers were introduced to the group and given fatherly advice as to their actions in the hospital. Augmented by some doctors, the volunteers had built up an orchestra among themselves and, as Lou Herman, the orchestra organizer and leader, declared, they played for their own amazement.

Chance for 16 Year Olds

Just before school closed in Albany a five hour course in simple floor work was given to 15 high school girls. This group of 16 year olds is proving an indispensable aid this summer when the adult volunteers have little children at home all the time or husbands wanting

"I'M READY FOR *Dessert*"

How OFTEN that is heard, and how often it expresses food preferences! How much better it would be if roly-poly youngsters should have dessert as a reward for eating a full, well-balanced meal, and not merely to satisfy a taste for sweets. It is not wise to permit children to become markedly overweight, especially when they have a diabetic ancestry. Obesity may be an etiological factor when diabetes appears in the hereditarily predisposed.

Iletin (Insulin, Lilly), the first Insulin commercially available in the United States. Protamine, Zinc & Iletin (Insulin, Lilly) for prolonged effect. Eli Lilly and Company, Indianapolis 6, Indiana, U.S.A.

Lilly BUY WAR BONDS FOR VICTORY

their companionship on vacations and when victory gardens or canning takes extra labor at certain periods. The girls assist in the care of flowers, bedside tables, drinking glasses and tubes, pitchers and luncheon trays.

You're Welcome, If—

"The Van Wert County Hospital welcomes visitors who follow these simple, sensible rules."

So it says on the cover of a tiny four page folder on "Visiting With the Sick" distributed to visitors at this 44 bed Ohio institution, of which H. M. Gee is superintendent.

Listing hours, restricting visiting to two persons at a time and giving hints to those who would help their friends and relatives get well, rather than hinder their progress, the booklet also announces that the hospital has printed cards to inform patients of telephone calls or of visits made when they were not able to receive the well-wishers.

Administration Without Tears

Blood, sweat and tears are a part of any hospital administrator's job in war time. All other shortages pale in comparison with personnel shortages and the threat of tears comes when the results of years of effort in building good will are jeopardized because some stupid or surly new employe is quite unnecessarily discourteous to a bed patient or his relatives.

Elmina L. Snow, R.N., head of Cortland County Hospital, Cortland, N. Y., took a long step toward administration without tears recently when she put out a snappy four-colored printed booklet on personnel policies. Her blood and her sweat went into that booklet but its content has helped considerably to eliminate tears on the part of both administrator and patients.

Let's look at Miss Snow's eight page folder for a minute. Its yellow cover is broken by the A.H.A.'s "Hospital Work Is War Work" emblem, done in red, white and blue. Page 2 is an employes' pledge, to be referred to later.

Page 3 is background material on the hospital and its tradition of service to the sick to whose comfort and well being all the work of every employe points. There are a paragraph of hospital history, some prideful statistics about the institution, just enough hospital organization for employes to know about trustee responsibility, management's job and their own importance in the setup.

The remaining pages list heads of departments, information about living quarters, employment practices, transfers and promotions, termination of service, pay days, bases of salary increases, legal holidays observed by the institution, vacation allowances, health service, Blue Cross membership, fire drills and safety, restrooms, laundry service, practice in regard to personal telephone messages and calls, loss of property by theft, breakage liability, employe suggestions for improvement of service and handling of employe grievances.

The final page ends with a complete little section on courtesy, stating that the majority of complaints these days concern lack of courtesy or consideration shown patients or the public by employes. "This dissatisfaction could have been avoided had the offender used sufficient tact or been endowed with ordinary kindness. Try not to give short snappy answers to persons asking information. Courtesy and sympathy should prevail at all times."

Miss Snow might have said to herself, "If I were head of a thousand bed hospital I think I'd get out a nice booklet on personnel policies to instruct each employe in our way of life. But what can a hospital of 125 beds do that would be practical in that line!"

But Miss Snow said nothing of the sort. She went to work and put out just as effective a booklet as if she had been the head of a thousand bed institution and she has been well repaid for her labors in improved morale.

Employes' Pledge

Here is the 14 point pledge that Cortland County Hospital implants in the minds of its workers:

1. I will arrive at work on time or ahead of time, keen and alert from a good night's rest.
2. I will leave my home problems, my financial problems and my social problems outside the building.
3. I will put in an honest effort every minute in the interest of the hospital. This will be good for the hospital and better for me.
4. I will make it my duty to see that every patient and visitor is treated with the same courteous consideration I would show a guest in my home.
5. I will show myself superior in self-control and in manners to those disagreeable people we come in contact with.
6. I will avoid idle gossip and criticism of others.
7. I will study and make notes of the wishes of my patients and report them to my superiors.
8. I will "do unto patients" as I would like them to "do unto me" if our situations were reversed.
9. I will spend part of my spare time studying to become a better employe.
10. No gum chewing for me in work hours.
11. No slangy talk with patients or visitors.
12. I will never go into a huddle with other employes to talk over personal matters while patients are awaiting attention from me.
13. I will be especially careful not to hurt the feelings of patients who have very little money.
14. I will treat every patient as though he were the best patient the hospital would ever have.

Doesn't that make you as an administrator want to "pull up your own socks" just to read it?

Procedures in Print

Students enter oftener and in larger groups, staff nurses come and go in endless procession, retired and married nurses return to the wards a bit rusty on procedures—these are signs of war times in our civilian hospitals.

Miami Valley Hospital in Dayton, Ohio, had been getting along some way without a procedure book; just how it managed to perform cannot now be fathomed by the nursing staff.

For in A.D. 1944 the superintendent of nurses and the faculty of the school of nursing have authored and published three hefty manuals for the student and graduate staff. These three books have simplified and standardized the whole nursing care of patients so satisfactorily that to return to the pre-1944 status would be unthinkable.

The master work of the series is the Nursing Procedure Manual, a compilation of practical instructions and technics that takes 261 closely mimeographed pages. The index to these procedures alone covers almost 10 full pages.

But don't let that stagger you for now we open the second procedure book, the Obstetrical Nursing Procedure Manual. This compendium of nursing routines is the work of Florence Stewart, instructor in obstetrical nursing, and it probably runs a good 80 pages.

The third volume of the series is an Experience Record for Student Nurses, prepared by the nursing faculty.

This is a book of forms that the student nurse must fill in. When properly filled in, the forms are graphic evidence that a student has had experience in all essential nursing procedures and has received balanced experience in nursing the commoner diseases.

To obtain and record her experience is made the student's own responsibility. The instructors or head nurses check off the procedures on the student's chart when in clinical practice she has performed each of them satisfactorily. The record of clinical experience is checked at the beginning and end of each special service to which the student is assigned.

READER OPINION

Canned Ether

Sirs:

For some time in this hospital we used bulk ether which we obtained in 50 pound drums. As far as the clinical administration was concerned, there was no appreciable difference between that ether and the ether specially prepared for anesthesia.

We discontinued the use of drum ether for four reasons. First, on two separate occasions we had ether delivered to us which was discolored and upon being tested in the chemistry department it was designated as motor ether.

Second, our problem of dispensing was somewhat difficult and the wastage seemed to be high. If one individual can always do it and he is careful, the problem of wastage need not be great.

Third, we rarely use any open-drop ether except for children. Absorption technics, local blocks, spinals, cyclopropane and other anesthetic agents and methods have contributed to the decline in open-drop ether cases. When ether is used, it is more frequently used in conjunction with nitrous oxide as either a fractional rebreathing or absorption technic.

Fourth, since this hospital is comparatively small, the saving was not apparent when balanced against the wastage. Our total number of anesthesia cases a month runs up to, but rarely exceeds, 225. In a large department, I think I would be in favor of drum ether.

E. H. Watts, M.D.
Director of Anesthesia
University of Alberta Hospital
Edmonton

"Somewhere in Italy"

Sirs:

After more than eighteen months we are really seeing some action. We have been in Italy a matter of weeks now and while we are a 750 bed evacuation hospital all units over here practically double their capacities so you can imagine our business. It never works out to double the personnel though. I have that headache and have been borrowing men from every unit I can.

As commander of the medical detachment, my work is that of getting the setup established and the more than 200 tents pitched and equipped. After that all I have to worry about is the transportation of all supplies, personnel and equipment (which is never adequate) and the assigning and welfare of the enlisted personnel.

Our patients are chiefly French and French colonial. Great fighters and not a gold brick among them. It does add to our difficulty, though, as we try to talk French to them, Italian to the scores of civilian workers and plain U. S. to the hundreds of G.I.'s who are getting their first shot at battle casualties. It's a great and interesting life.

Certainly will be glad when this mess is over and I can get back to the many friends in the hospital field. We M.A.C.'s sort of feel like the forgotten men of the Army. The amount of hospital administration most are doing is a joke.

Capt. W. G. Simmons
27th Evacuation Hospital
APO 758
c/o Postmaster, New York

Only a Neurosis

Sirs:

The attached poem is from Dr. E. L. Demuth, formerly assistant director of Montefiore Hospital, New York City.

E. M. Bluestone, M.D.
Director
Montefiore Hospital
New York City

We hope that you appreciate
The efforts made within these gates
To diagnose a rare disease
And put a soldier at his ease.

One patient says "I can't breathe well,
I've got tuberculosis."
We Freudian physicians know
It's really a neurosis.

When a man begins to scratch
Is it pediculosis?
Don't blame the lice, that isn't nice,
It's really a neurosis.

A soldier claims his breath is foul
It must be halitosis
But in this sheltered atmosphere
It's really a neurosis.

If patients should develop boils
Is it furunculosis?
It's more involved than just "skin deep"
It's really a neurosis.

We follow Cromwell—Challman, too,
Keep life in proper focus
But subconsciously we know
We've all got a neurosis.

And if a patient says to us
"My trouble's not neurosis,"
Then we clever doctors know
THAT man has a psychosis.

Capt. E. L. Demuth, M.C.
Somewhere in New Guinea. May 1944.

SMALL HOSPITAL QUESTIONS

Conducted by Gladys Brandt, R.N., Children's Free Hospital, Louisville, Ky.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; William J. Donnelly, Greenwich Hospital, Greenwich, Conn., and others

Discounts for Service

Question: What discounts, if any, should be given to the hospital trustees or their families, to doctors and their families, for hospital service?—W.W.L., S. C.

ANSWER: Discounts to hospital trustees and their families or to doctors and their families is a perennial problem in every hospital. It is a serious question whether such discounts should be extended. Justification for such policy can hardly be defended. Doctors have all the advantages of the hospital without cost and directors of hospitals hold their positions as trustees for the community and do so, if the organization is a tax-free, nonprofit concern, with the understanding that they will receive no remuneration of any sort for their services. In practice, however, I believe most hospitals provide some type of discount for these two categories.—JOSEPH G. NORBY.

When Is Pay Day?

Question: Is there any justification for paying employes weekly rather than semimonthly or monthly?—A.J., Utah.

ANSWER: There is little justification for paying employes weekly rather than semimonthly. I do not like the monthly pay roll because it is too long a period for people on relatively small salaries to budget themselves easily. For relief help and with the rapid turnover that is now being experienced, it is confusing to the pay roll department to have to be making checks inside of the pay roll period and then remembering when the final pay roll is made up which checks have been paid. It would seem that the semimonthly pay roll is the correct answer because that is a long enough period to keep temporary employes so that they get adjusted to the program and meet their own budget satisfactorily.—NELLIE GORGAS.

How About a Budget?

Question: Should a small hospital attempt to operate a budget? If so, what should be the budget period and how much detail should it contain?—R.D., Pa.

ANSWER: For a small hospital to attempt to set up a line budget is, in my opinion, a folly. However, I do think it is helpful to have a predetermined idea of what your maximum cost per patient day can be. This figure can be arrived at by estimating what the income per patient day will be and adding the known nonoperating income, such as income from endowments and the like.

Income and expense should be watched closely and a monthly summary prepared to serve as a guide for the administrator. The administrator should never permit the deficit to exceed an amount that can be financed. If income drops to an uncomfortable level, one of two things must be done: either rates should be increased to produce additional income or expenses must be decreased. Sometimes a combination of the two will meet the need. It is wise, of course, to have a salary schedule that will serve as a guide, or a budget, if you will, for this major portion of your expense.—WILLIAM J. DONNELLY.

Hospital Care for Employes

Question: What policy is generally followed in giving free hospitalization to employes? Are employes required to carry hospital insurance or pay for their own hospitalization?—W.W.L., S. C.

ANSWER: Hospital employes are not given free hospitalization at Columbia Hospital since the advent of Blue Cross service in Milwaukee. However, all new employes who are on a permanent basis are required to carry Blue Cross contracts. In the event that they are hospitalized they are given complete service without additional cost. The employes pay for this insurance themselves and the amount is deducted from their check regularly each month.

In a recent agreement with nurses in the Alameda County area, California, the hospitals agreed to provide Blue Cross coverage at hospital expense to all graduate nurses. There is today quite a tendency in industry to provide Blue Cross at the employer's expense. Some hospitals pay the cost; others do not.—JOSEPH G. NORBY.

Charge for Blood Donations

Question: When enough blood is drawn from one donor for two transfusions do most hospitals charge as much for the second transfusion as for the first one?—C.J.G., N.C.

ANSWER: Most of the hospitals make no additional charge for taking the blood inasmuch as the setup is identical, with the exception of the receptacle, when the blood is taken for one or two transfusions. There would, of course, be a separate charge for administration of the second transfusion equivalent to the charge for the first.—A. A. AITA.

Keep Up Vacations

Question: What policy can be established under present conditions for vacations and holidays? Can hospitals give vacations during the present acute shortage of employes?—J.R.D., N. J.

ANSWER: Under present conditions it is more important than ever that correct policies with regard to vacations and holidays be maintained if at all possible. Of course, in some localities labor shortage is greater than in others and perhaps it is impossible to maintain the same standards as in other years. However, every possible effort should be made to fill in with school vacation help, volunteers, part-time workers and any other source of labor supply so as to allow the permanent members of the staff their vacations. They are being pressed harder than ever before all during the year and can only continue if they do get some relief. This places still further burdens on the administrative staff to find the relief personnel and to supervise it, but in most places it can be done if everyone is on his mettle to round up all possible relief help.—NELLIE GORGAS.

Handling Cash

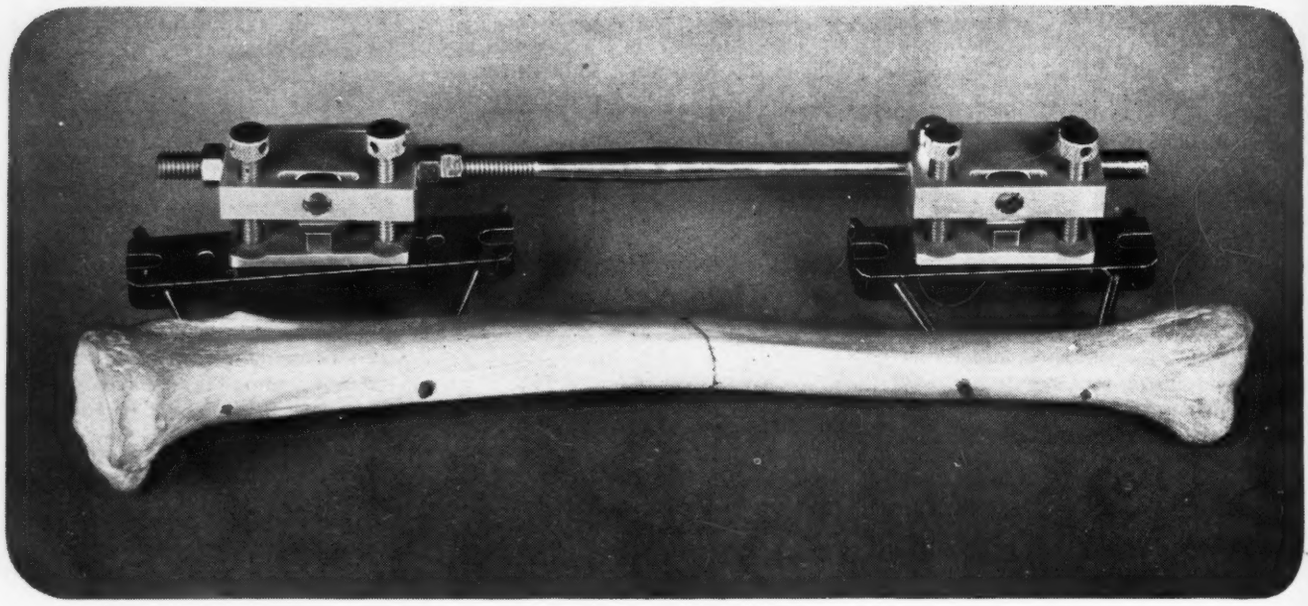
Question: How many people should actually handle cash receipts from patients? How can this number be kept at a minimum and what provision should be made for nights and week ends?—M.R.S., Kan.

ANSWER: It is probably impossible to designate less than two persons for handling cash receipts from patients and you will probably find at least two or three more accepting payments at one time or another. I think that the persons handling cash receipts should be kept to the lowest number consistent with service to the patient.

While more than two persons will accept payments, one individual should be held responsible for making deposits and keeping a record of cash collections. For purpose of control, some other person should be responsible for the posting of payments to the patients' accounts.

The telephone operator could be responsible for night and Sunday collections unless there is sufficient activity to warrant having an extra person during these hours. I would counsel against adding responsibility for accepting cash payments to the work of the night supervisor.—WILLIAM J. DONNELLY.

To Help You Evaluate the Stader Splint for External Skeletal Fixation . . .



. . . here are some of the advantages which it offers as an aid to treatment results in most fracture cases

- Because it employs a sound mechanical principle it combines, in a single compact unit, the means for not only accurately controlling reduction but also for securely retaining fixation.

- Its application obviates the use of extension apparatus, special reduction frames, and plaster casts—the elimination of which means an unrestricted circulation essential to bone repair.

- It bridges the fracture with a single adjustable connecting bar which serves as the splint, and assures the essential fixation.

- Applying it to one aspect of the fractured limb only, it affords complete articular freedom above and below the fracture, and thus minimizes joint disabilities due to long periods of immobilization.

- The seven available Stader splints provide for the reduction and fixation of fractures of the humerus, radius and ulna, femur, tibia and fibula, os calcis, clavicle, and mandible.

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LOOKING FORWARD

The Mountain Labored

THOSE who have been following the work of the A.H.A. board of trustees in the development of a set of principles in regard to the future program of the association will be considerably disappointed at the result. The statement appears in the July issue of *Hospitals* on pages 14 and 16.

President Walter originally presented a statement with considerably more real meat. Apparently in the process of revision and amendment much of that meat has been trimmed off. We can hope that the public will not consider that it has been given only the bones. But if such is the reaction, it will not be surprising.

In essence, the statement is merely a rephrasing of what hospitals have been affirming was their policy for the last two or three generations. Two items are somewhat new, namely, "participation in a program of preventive medicine" and "extension of rural-urban hospital coordination." It is good to have these in the program.

When the newly formed Commission on Hospital Care gets under way it is to be devoutly hoped that it will be able to produce a program for hospitals that has more in it to stir men's blood. It will be surprising if this statement, in its present form, will even be remembered in 1949.

In the Trustee Lies Our Strength

IN THE final analysis, responsibility for the welfare and advancement of our hospitals rests on the hospital trustees (or in governmental institutions on the councils or boards that perform the functions of trustees).

The administrator, his department heads and the medical staff may make recommendations as to policies and procedures. These can become effective, however, only to the extent that the trustees approve them or delegate authority for their approval.

Thus the voluntary hospitals, particularly, are directly dependent upon the extent to which trustees understand their duties and responsibilities and perform them effectively. While lay trustees will usually listen with great respect to the advice of professional personnel, they should not abdicate their own powers. If they do, a day of reckoning is almost sure to come.

However, if the trustees are actually to decide the major matters of policy that arise in the life of the hospital, they should be well informed. They should know of the principal currents of thought that are moving through the hospital field. They should have an opportunity to read such materials as the trustee reprints made available by this magazine.

Furthermore, they ought to have an opportunity to get together for discussions of hospital problems from time to time. If the hospital trustees of America could attain a real esprit de corps and sense of solidarity through the development of trustee associations, the cause of hospitals would go forward even more rapidly. Progressive administrators will welcome such greater interest and information on the part of trustees.

Public Relations Institute

THE success that has attended the institutes on hospital personnel management, accounting and purchasing suggests that the A.H.A. might render a valuable service if it would sponsor a similar five day institute on public relations. While as yet relatively few hospitals have employed public relations directors on a full-time basis, the same is true of personnel directors. Yet the interest in personnel relations on the part of administrators and assistant administrators was sufficient to make an institute on this subject an overwhelming success.

There is today equal interest in public relations and such an institute would undoubtedly be highly successful. Perhaps there is not so large a body of tested experience and technic but there is much more than can be crowded into five very busy days.

Municipal Hospitals

A WELL-TRAINED hospital administrator left a good position about a year ago to take charge of a new city-county hospital built with Lanham Act funds. He is now so disgusted with the arrangement that he is seeking another position.

The hospital has a seven man board, three appointed by the city, three by the county and the seventh by these six. The president of the board is a small merchant with one employe beside himself. The treasurer sells insurance and has sold all of the insurance on the hospital. The remaining members of the board

leave something to be desired. The superintendent is permitted to hire employes but cannot fire anyone until the board has actually interviewed the employe and approved the discharge. Many of the board members have incomes well below the meager salary of the superintendent.

Obviously, the federal government does not want to dictate to hospitals what people shall constitute their boards. But something is seriously wrong when this kind of a board results. Something should be done to educate local officials who obtain federal funds for new hospitals as to the caliber and capacity needed in hospital trustees. This situation constitutes a scandal.

Pensions for All Employes

SEVERAL of the hospital administrators who have commented on the series of articles in this magazine advocating pensions for hospital employes have suggested that the American Hospital Association should organize a program along this line similar to that of the Y.M.C.A. and some other national groups. This is a splendid idea. There is so much change in employment that some hospital employes would obtain little benefit if they had to start at the beginning again each time they went from one hospital to another.

The stabilizing of employment is, of course, one of the purposes for which a hospital would be willing to pay the cost of a pension plan. But, viewed realistically, most of us realize that a certain amount of progressing from one hospital to another is inevitable and, indeed, desirable. There are dangers of inbreeding when a hospital keeps the same personnel on year after year. Frequently good ideas can be obtained from a new employe who has worked in three or four other hospitals. Too, the administrator and major department heads often look to changes of employment as the logical method of advancement.

Many problems must be settled before the A.H.A. could offer such a service to its members. But the problems are not insolvable. A program that will act as an effective supplement for the benefits of the Social Security Act can well be developed by the A.H.A.

Don't Exploit Volunteers

A RECENT applicant for an office position at one of our larger hospitals was reluctant to accept at the salary offered. "We don't have to pay salaries any higher than this," the interviewer told her, "because we have lots of volunteers to do the work if we can't get paid employes at these salaries."

Probably the person conducting the interview grossly misrepresented the position of the hospital in question, since it is known to be one of the highest paying institutions in its city. But to make such a remark was a grievous error. It represented a gross misconception of the proper rôle of hospital volunteers and an unfair attitude toward the hospital's employes.

If hospital volunteers believed that they were being used by the hospital to depress wage and salary levels for regular employes, many of them would resent it. It would be well for every hospital to make its policy clear on this point.

Interest in Education

A NEW departure indicating real interest in the training of hospital administrators was the recent gift by the New England Hospital Assembly of $100 for a scholarship to be awarded by the University of Chicago to a student in its hospital administration course. While the student is to be preferably from New England, this preference is not to be construed as a restriction. The check came unsolicited and was warmly welcomed by the University of Chicago.

The New England Hospital Assembly has shown its public interest in other ways. For several years it has sent unsolicited contributions to aid in the development of the Bacon Library of the A.H.A. Such public spirit merits recognition.

Help for Small Hospitals

HOSPITAL administrators, physicians in small towns and rural areas, public health administrators, hospital architects and others who are interested in the advancement of rural health will be much interested in the $5000 contest announced in this issue.

This journal is offering substantial prizes for the best design of a 40 bed general hospital and similar prizes for the best design of a 40 bed community health center. The original program, as printed in this issue, called for a 25 bed general hospital and a 25 bed community health center. Further advice from experts, however, has made it clear that each of these should have 40 beds.

It is hoped that there will be many team entries, as well as individual entries, in the contest. An architect, a hospital administrator and a health officer might well make up such a team. Or a physician practicing in a small community might join with an architect. Or a consultant and an architect might collaborate.

The program is planned to bring to light the best ideas concerning the design of small hospitals and to stimulate progressive thinking concerning two other ideas: the integration of rural public health work with hospitals and the centering of rural medical practice in hospitals.

Many authorities agree that a 40 bed hospital is too small for most economical and efficient operation. Hence, provision is to be made for expansion to a 60 bed hospital when the demands of the community justify such expansion. From surveys of rural hospitals, it is apparent that the existence of a good community hospital soon increases public demand for its service.

Since a high level of rural health is essential to the nation, every hospital administrator should be eager to promote this contest.

HEADLINE NEWS

Hospital Care Commission to Hold First Meeting

The Commission on Hospital Care is nearly complete as to membership and the first meeting was scheduled for Philadelphia on August 1.

In addition to the chairman, Thomas S. Gates, president of the University of Pennsylvania, whose appointment was announced in the July issue, others who have accepted the invitation from the American Hospital Association to date are: Herbert Hoover; Katherine J. Densford, dean of the school of nursing, University of Minnesota; Albert W. Dent, president, Dillard University, New Orleans; Dr. Wilton L. Halverson, commissioner of health of California; Ada Belle McCleery, former administrator of Evanston Hospital, Evanston, Ill.; Dr. Leroy M. S. Miner, dean of the school of dentistry, Harvard University; Dr. Claude W. Munger, director, St. Luke's Hospital, New York City; Msgr. Thomas O'Dwyer, director of Catholic Charities, Los Angeles.

Additional members are: Clarence Poe, editor, *Progressive Farmer,* Raleigh, N. C.; Dr. Willard C. Rappleye, dean, College of Physicians and Surgeons, Columbia University; Edward L. Ryerson, chairman of the board, Inland Steel Corporation, Chicago; J. Berrye Wall, Southside Community Hospital, Farmville, Va.; Frank J. Walter, president, American Hospital Association; Matthew Woll, vice president, American Federation of Labor; Charles P. Cooper, vice president and director, American Telephone and Telegraph Company; Dr. Evarts Graham, professor of surgery, Washington University, St. Louis; Clinton S. Golden, assistant to the president, C.I.O.

More Time to Seek Food Allotments

WASHINGTON, D. C.—Hospitals and other institutions since July 1 have been permitted by O.P.A. an extension of time for filing applications for rationed food allotments if they cannot compile the necessary information in the fifteen days ordinarily permitted. The hospital must apply to the local ration board for permission to file application for allotment later than the time fixed. If the board is satisfied that the institution cannot reasonably compile the required information within the first fifteen days of an allotment period, it may extend the time but not beyond the first thirty days of the allotment period.

Parran Cites Postwar Need for Hospitals at Hearing on War-Time Health Program

By EVA ADAMS CROSS

WASHINGTON, D. C.—A need for 417,000 more civilian hospital beds was outlined at a series of public hearings on the nation's war-time health program, held here July 10 to 12 before the Senate special sub-committee on war-time health and education.

Among top-ranking Army, Navy, Public Health and other officials to present testimony on various phases of war-time health problems were: V/A Ross T. McIntire, Maj. Gen. George F. Lull, Dr. Thomas Parran, Maj. Gen. Lewis B. Hershey, Brig. Gen. Frank T. Hines, Col. Leonard Rowntree, Paul V. McNutt, Dr. Vane M. Hoge and Dr. Claude W. Munger, representing the Council on Government Relations of the A.H.A., and Dr. Victor Johnson, secretary of the Council on Medical Education and Hospitals of the A.M.A.

In his testimony Doctor Parran predicted a postwar demand for hospitals to "exceed anything we have known in the past." Evaluating the adequacy of hospital care, he said that a total of 166,000 additional general beds is needed (66,000 of them as replacements) at an expenditure of approximately a billion dollars; in addition, there is need for approximately 191,000 beds (97,000 as replacements) at a cost of $573,000,000 for nervous and mental hospitals, and an estimated total of 60,000 beds (16,000 as replacements) at a cost of $300,000,000 for tuberculosis hospitals. He also estimated a need for 1200 district health centers and 1200 district health subcenters at a cost of $117,000,000.

Doctor Parran stressed the lack of adequate facilities for the care of patients with chronic diseases. Chronic cases are cared for largely in the infirmaries of institutions and in private, low-cost nursing homes, he said. "No estimates are yet available on the scope of this problem but it is known to be of considerable magnitude."

He urged a program of federal assistance to the states for the medical and hospital care of individuals in the low-income group.

"A program of this nature should include not only the care of acutely ill persons but also the care of chronic disease which is largely a part of the same social problem. With the charity load removed, voluntary hospitals will be able to give a more complete service at lower cost to those patients able to pay either insurance contributions or fees for service."

He urged that in the less wealthy areas consideration be given to the combining of public health and limited hospital facilities in the same building.

Caution Against Haste

Doctor Munger and Doctor Johnson cautioned against haste in adopting any plan that does not allow freedom for voluntary hospitals and does not take into account differing conditions in various areas. Doctor Munger emphasized the advantage of Blue Cross and similar plans. This was approved by Doctor Parran but he said that "the charges in proportion to the service rendered are so high as to be prohibitive when applied to the general population."

Petry Urges Guidance for Senior Nurse Students

WASHINGTON, D. C.—Most careful guidance for senior nurse students and recently graduated nurses in determining where they can make their best contribution to the war effort was urged by Lucile Petry in a memorandum to directors of schools of nursing dated June 27.

In every graduating class, said Miss Petry, there will be some who should enter the armed services; some who should fill immediately those critical nursing positions not requiring special postgraduate preparation, and some who should, if qualified, undertake postgraduate study to prepare for critical nursing positions requiring special preparation.

Directors of schools of nursing are advised to review the capabilities and potential aptitudes of each senior student to determine the field of nursing into which she should go. Attainable goals are mentioned as is the need for acquainting the student with the "criteria" of essentialities for nursing.

Student nurses, said Miss Petry, should be directed to clear their tentative classifications with the local Council on Procurement and Assignment as soon as they become graduate nurses. Those graduates not in military service should be encouraged to make immediate application to the American Red Cross.

Public Health Service Act Signed; Parran Enumerates Benefits

WASHINGTON, D. C.—The new Public Health Service Act, passed without a dissenting vote by the House and the Senate, was signed by President Roosevelt on July 3.

The new law will enable the U. S. Public Health Service to make further federal grants-in-aid for research in disease; authorize a nation-wide attack on tuberculosis; strengthen the commissioned corps of public health officers; provide for the commissioning of public health nurses; confirm the broad powers and duties of the U. S. Public Health Service with respect to foreign and interstate quarantine and to the medical and hospital care of the merchant seamen and its medical service to the Coast Guard, and facilitate the smooth operation of the federal-state public health program.

The U.S.P.H.S. has already made plans for a national tuberculosis control program which will be put into effect as rapidly as possible when necessary funds are appropriated this year, according to Dr. Herman E. Hilleboe, medical officer in charge of the newly established tuberculosis control division.

When Congress appropriates the authorized funds, the new division will be able to conduct a $10,000,000 program for tuberculosis control similar to the national program of venereal disease control. Functions of the new division will include:

1. Developing more effective measures for the prevention, treatment and control of tuberculosis.

2. Assisting states, counties, health districts and other political subdivisions in establishing and maintaining adequate measures for the prevention, treatment and control of tuberculosis.

3. Preventing the spread of tuberculosis in interstate traffic.

"G.I." Bill Spurs Program of Veterans Administration

WASHINGTON, D. C.—Following enactment of the "G.I. Bill of Rights" making possible a $70,000,000 hospital building program, the Veterans Administration has recommended that the Federal Board of Hospitalization approve new building projects totaling 16,000 additional veterans' hospital beds to be constructed in 20 different states, according to Brig. Gen. Frank T. Hines in a statement July 5.

Thus the "Servicemen's Readjustment Act of 1944," which became Public Law 346 with the President's signature June 22, is being carried into effect with all possible expedition.

The 16,000 bed program consists of three types of permanent fireproof modern hospitals as follows: 5000 beds for neuropsychiatric patients; 3000 beds for tuberculous patients, and about 8000 beds for general medical and surgical patients.

The Veterans Administration now has some 88,000 beds of all types. Authorized are 17,000 more neuropsychiatric beds, facilities for some of which are now under construction. The addition of the 16,000 beds just requested will bring the grand total of beds of all types to 121,000.

The states in which the new beds will be located include New Hampshire, Rhode Island, Delaware, Virginia, Florida, Michigan, Kentucky, Louisiana, Mississippi or Alabama, eastern Kansas or northern Missouri, eastern Montana or western North Dakota, Colorado, California, Texas, Washington, New York, Georgia, Ohio, Pennsylvania and Illinois.

Additional facilities, whether for hospital or medical care or for administration of other benefits, will be created as rapidly as necessity requires. A total of $500,000,000 has been made available by the bill for additional hospital facilities. Prior to its enactment, it had been estimated that 300,000 beds in all would be required.

The Army and Navy plan to turn over in time 100,000 beds to the Veterans Administration. The gradual construction of another 100,000 as required has been planned. Hospitalization is extended to veterans of all our wars without regard to service connection for disability.

Veterans' Hospitals Need Nurses

WASHINGTON, D. C.—There is a present shortage of 967 qualified nurses in 88 of the 94 veterans' hospitals, the administrator of Veterans Affairs declared July 10. The veterans' hospitals, located in all of the states but three and in the District of Columbia, are classified into three groups: general medical and surgical, tuberculosis and neuropsychiatric. The administrator appealed to graduate nurses of recognized schools of nursing to serve the nation's disabled veterans. "Serve those who have served you," he said.

U. S. Cadet Nurse Corps Exceeds Recruitment Quota

By EVA ADAMS CROSS

WASHINGTON, D. C.—The U. S. Cadet Nurse Corps has exceeded its quota of 65,000 by more than 500, Dr. Thomas Parran, surgeon general, U. S. Public Health Service, declared June 30.

The cadet nurse corps on the eve of its first birthday had rolled up a total membership of more than 100,000. Besides new student nurses, this group includes second and third year students who transferred to the corps during its first year. These students in more than 1070 approved schools of nursing are contributing to the war-time program while they prepare for a nursing career.

Doctor Parran paid special tribute to various groups for their superhuman efforts in helping the corps to go over the top. Among those receiving high praise were: recruitment committees of the National Nursing Council for War Service and their affiliated state and local councils; schools of nursing; state boards of nurse examiners; the American Hospital Association; guidance counselors in high schools, colleges and universities; the War Advertising Council; the war activities' committee of the Motion Picture Industry; the Office of War Information, and the Federal Works Agency.

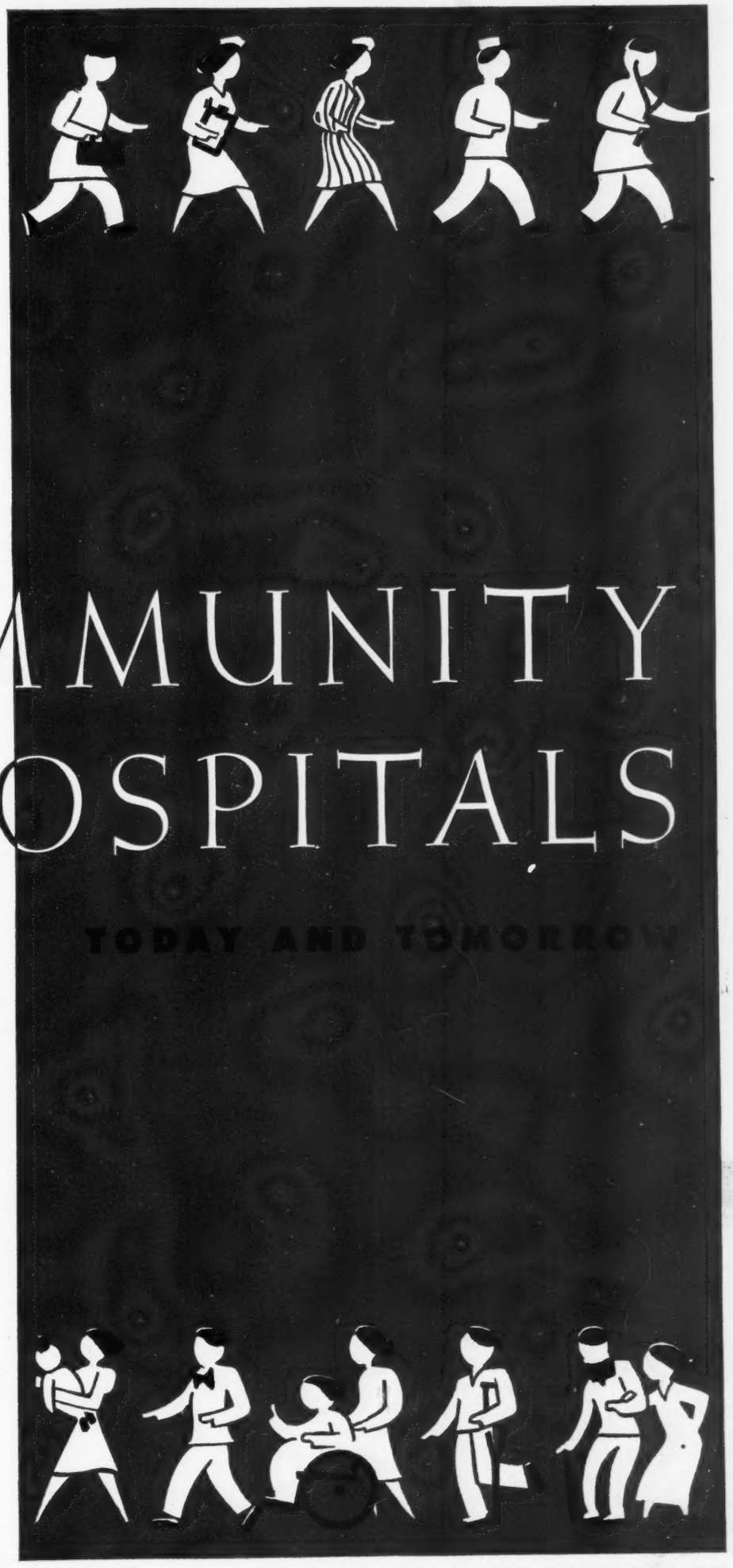
At the special first anniversary ceremony on July 1, Doctor Parran formally presented the official flag of the corps. It was accepted by Lucile Petry, director, on behalf of the organization. The flag is white, silver and scarlet emblazoned with the maltese cross. Forty uniformed cadets formed a guard of honor for the ceremony.

E.M.I.C. Program Sets Record

WASHINGTON, D. C.—It is anticipated that some 500,000 wives and babies of servicemen will be cared for in the next twelve months under the emergency maternity and infant care program, according to a statement July 9 from the Children's Bureau. More than 40,000 cases are now being authorized monthly. Wives and babies of Army aviation cadets are now eligible for care along with families of men in the four lowest pay grades of the Army, Navy, Marine Corps and Coast Guard. Congress appropriated $42,800,000 for the program for the current fiscal year.

Wac Technicians Needed

The Army is seeking 22,000 members of the Wac to serve as medical technicians in hospitals in which battle casualties are being rehabilitated.



A PORTFOLIO OF PLANS AND IDEAS PREPARED BY THE MODERN HOSPITAL IN COLLABORATION WITH THE EDITORS OF ARCHITECTURAL RECORD + + + + +

HEALTH SERVICES IN CITY PLANNING

EDWIN SALMON
Chairman, City Planning Commission
Chairman, Hospital Council of Greater New York

THE real significance of the relationship between over-all city planning and planning for health services in New York City is indicated in the provisions of the New York City charter under which the planning commission functions and in the objectives of the Hospital Council of Greater New York, a voluntary agency.

The charter, among other important items, requires the commission to prepare a master plan for the city which shall show all types of public improvements, private utilities, sites for public buildings, building zone districts and all other "such feaures, changes and additions as will provide for the improvement of the city and its future growth and development and afford adequate facilities for the housing, transportation, distribution, comfort, convenience, *health and welfare* of its population."

The constitution of the hospital council states among other objectives that it shall "coordinate and improve the hospital and health services of New York City and plan the development of these services in relation to community needs."

The city master plan would be totally inadequate and incomplete without a plan for hospital and health facilities and the hospital council's work would be quite ineffective if not geared to the over-all city plan.

With this in mind the city planning commission requested the hospital council to undertake the study and preparation of a master plan for hospitals to include municipal and voluntary institutions. The commission has offered the full cooperation of the city agencies and full use of all available general planning data. The council has received grants from voluntary fund-raising organizations to develop this project, which is now well under way.

A master plan for hospitals and related facilities should show (1) all existing hospitals and institutions for the care of the sick that have been determined to be satisfactorily located and that provide adequate facilities and distribution of clinical services for the communities to be served; (2) those existing hospitals and institutions that are satisfactorily located but require certain modifications and additions, and (3) all proposed new facilities that are deemed to be desirable and that, in addition to existing institutions, make adequate provisions for a comprehensive plan of hospitals.

Such a plan should indicate the recommended locations together with sufficient detail of each facility to provide a complete understanding of the services to be established. This plan must also be sufficiently flexible to lend itself to modification in structure or program from time to time to meet changing conditions and advancement in health and hospital procedures.

The technics for the development of such a plan for health services are not yet definite and the criteria for appraising the adequacy of existing facilities or establishing new ones must likewise be determined. Methods of approach to the development of formulas for this type of planning are being rapidly completed and the hospital council will publish a bulletin from time to time containing articles and planning data related to this problem.

Definite community planning factors that must be taken into consideration are: population distribution, trends and economic and social

characteristics; property uses and land developments; transportation and arterial highways; other community services and proposed improvements, including neighborhood developments and administrative district systems. In New York many of these features have been determined as integral parts of the total master plan and, as such, have a definite legal status and exert an effective control over future developments.

An important phase of this plan is the establishment of a complete district health administration program whereby the city has been divided into 30 health center districts, each containing a population of approximately 250,000 persons. Each area will be provided with a district health center building and sufficient substations to provide services as indicated by the health conditions of the various neighborhoods. Fifteen major health centers and 10 substations have been erected since 1935. Ten additional centers and nine substations are now being planned for construction in the immediate postwar period.

The statistical data concerning the health problems of each district compiled on a five year basis have been extremely useful in the development of the district plan and will also provide an important element in the determination of hospital requirements.

Many other aspects of general city planning could be discussed at length and are all related to neighborhood hospital planning but would require considerable space for presentation here; as there are now competent authorities at work on these problems, many of the answers will be forthcoming shortly.

There are several important and specific questions in the hospital field that must be resolved prior to the determination of the proper allocation of services on a community-wide basis. Some of these problems are:

How can we stabilize our communities in order to plan with assurance and offer reasonable opportunities for work, play, travel and minimum standard living conditions?

What effect will greatly increased air travel have on decentralization of industry and population?

Will air travel have a reverse effect upon hospitals, making the city medical center more accessible to outlying communities?

What effect will recent trends toward prepayment plans have upon a greater use of hospitals and health centers?

To what degree will medical services be divided into specialties, the family physican and preventive medicine and what type of facilities will be required for each?

How far can we go in combining community services for public health, hospitals and sanitation?

New York City recognizes that its master plan for the future would be incomplete without a plan for hospital and health facilities. Hence, the hospital council has been asked to prepare a master plan for hospitals with the full cooperation of all of the city agencies and use of all available planning data

What are workable communities and how important are their health statistics in the determination of the size of hospitals?

It is unlikely that uniform criteria or standard technics can be determined to suit hospital planning for all communities and it is further unlikely that any standards would remain static for any length of time but it is certain that the best can be developed only through the proper coordination of all planning activities.

City planners, architects and engineers, physicians and hospital administrators, business and financial leaders must combine their efforts toward the common goal of sane, logical over-all planning for the general welfare. The coordinated efforts of both government and private enterprise are absolutely essential to the ultimate success of the implementation of the complete master plan.

The master plan is essential to the intelligent and proper determination of all types of service plans based on an equitable distribution of hospital and health facilities and the possible development of hospital areas or districts similar to other administrative district systems.

It is, of course, important to maintain in this voluntary system a freedom of choice on the part of both patient and physician where the patient is able to pay full costs. And it is likewise important that all hospitals and health facilities included in prepayment plans of whatever type render full and competent services that will meet minimum standards.

It is with considerable confidence in the generally accepted policies of over-all planning that we are undertaking the difficult and complicated task of preparing a master plan of this kind. We all have a healthy respect for the magnitude of the problem and if this article appears to be on the side of oversimplification it is because of its brevity and not through ignorance of the facts.

Two most important factors that should be kept constantly in mind in our present planning are: first, the necessity for developing plans now for specific hospital projects of all categories from small modernization plans to large comprehensive centers that are urgently required to overcome increasing obsolescence of the older institutions and the needs for added services, and, second, the importance of having available complete plans and specifications for worth-while projects to provide immediate employment where and when required after the war for demobilized service men and women and war workers.

So much is required to meet our present inadequacies and deficiencies in all types of service facilities and so many projects can be determined without lengthy surveys and investigations that it is possible to develop now a substantial backlog of plans based on these obvious needs.

Long-range, visionary planning based on drastic revolutionary changes in our social and economic systems may make for interesting discussions and advancement of idealistic theories but will not produce jobs or provide necessary public improvements.

Realistic though limited objectives that are understandable to all and that will provide for the continuation and expansion of our present systems in meeting the real needs of the communities are what our fighting men and women expect of us in postwar planning, so that they may return to the homes they left in a recognizable America and put their shoulders to the wheel.

FROM COMMUNITY NEED TO COMPLETED BUILDING

PLAN THE PROGRAM STEP BY STEP

CLAUDE W. MUNGER, M. D.
DIRECTOR, ST. LUKE'S HOSPITAL, NEW YORK CITY

IN THE early days of hospital construction in this country, much of the planning was inadequate by present standards. If we will recall the changes in the methods and technics in the care of the sick that have occurred since some of our older hospitals were built, we will temper our criticism somewhat, realizing that present demands could not have been foreseen at the time of construction. Also, hospital architecture as a specialty within the art was almost unknown fifty years ago.

The costliness of early mistakes and their emphasis by sorely beset hospital boards and administrators have gradually served to school the whole hospital profession to the fact that money alone will not create a good hospital building. It has come to be generally recognized that hospital planning is a serious and complicated matter that requires the highly coordinated efforts of owner, architect and consultant.

The original suggestion that hospital construction be undertaken may arise from various sources. Whatever the inception of the idea to build, as soon as it reaches the stage at which it is to be seriously considered, it is most important that the hospital at once adopt an orderly plan of action.

The first logical step for the board of trustees to take is to call a conference within its own organization to deliberate upon the matter in a preliminary way. Usually, after general discussion, the board will name a committee of its own membership to study the proposal.

In the appointment of such a committee the board should consider the probability that the same committee may later become the building committee to supervise the construction project. If the board feels that the preliminary committee needs to be a larger group than would conveniently function as a building committee, it is quite permissible to proceed in that way but, if possible, the committee originally appointed should include persons who could be selected from it, later, to constitute the building committee.

The personnel of a building committee should include, insofar as possible, the strongest, most devoted and best informed members of the board. The president of the board, if not an active member, should have ex-officio membership.

It is my belief that the committee should consist of not less than three and not more than five members of the board. A larger committee would be unwieldy for meeting the many problems and for reaching the intercurrent decisions that will be necessary throughout the building project.

Should the hospital have a board member who is an architect, he or his firm, of course, will be ineligible for consideration for employment by the hospital, but such an architect might be a valuable member of the building committee. However, persons technically informed about construction are not absolutely essential to a properly functioning committee.

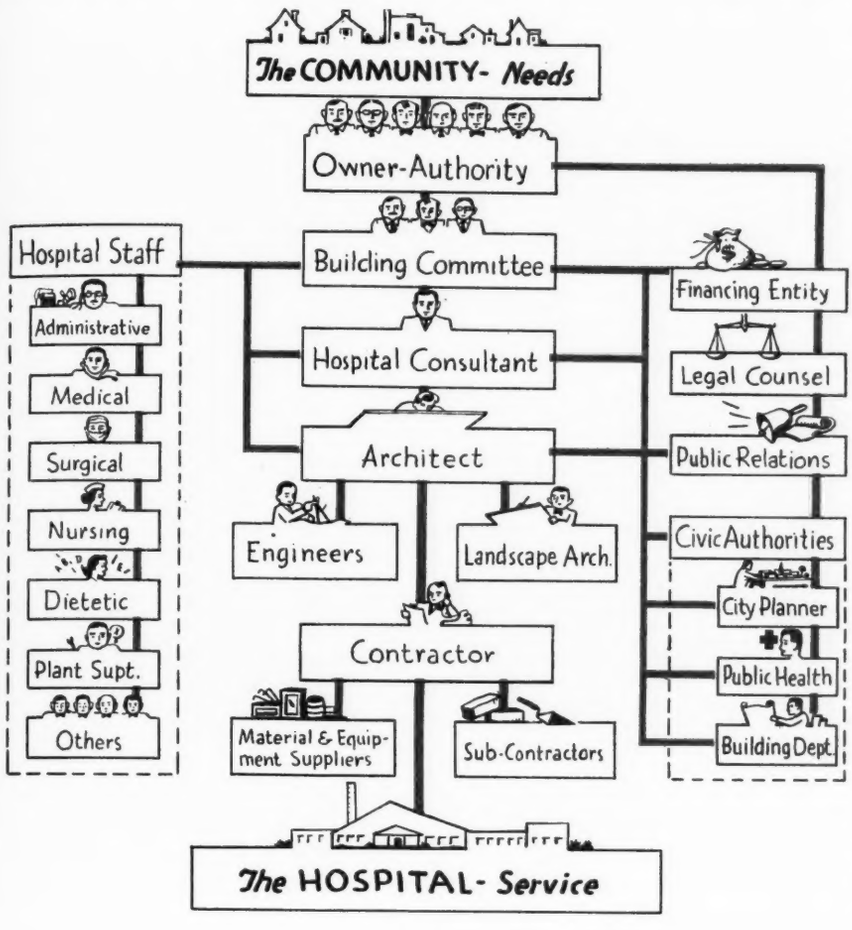
In addition to the president, the administrator of the hospital should have ex-officio membership in the committee, should attend all of its meetings and take an active part in its deliberations. In most hospital organizations he will be the person best informed as to the requirements of the building, and to ignore his potential helpfulness would usually be a great mistake.

The larger committee should early call a series of conferences to include a representative group or committee of the medical staff of the hospital, the administrator and such of his department heads as are appropriate. At these conferences, there should be the fullest discussion of the supposed need for construction and the thoughts of the groups in attendance should be fully explored.

In some instances, the proposed hospital construction may be for an entirely new institution, viz. neither an addition to nor a replacement of an existing hospital. In such instances, the procedure described in the preceding paragraphs is somewhat different, although it should follow the same general lines.

If a controlling board has not been organized, one should be set up in accordance with the laws of the particular state as a membership or eleemosynary corporation. In this connection the founding group should consult the appropriate reports of the American Hospital Association and other authorities as to the content of the charter and by-laws of the new corporation. The importance of

ORGANIZATION FOR COMMUNITY PLANNING



this can scarcely be overemphasized.

The new board would select its committee in much the same manner as an existing board. It would not have its own group of physicians or an administrative staff with which to consult but it would, logically, confer with the local medical profession and local social welfare agencies in rounding out its original thinking upon the need of a hospital. In this particular situation the early engagement of a hospital consultant is especially imperative.

In either of these situations, viz. the existing hospital or the entirely new hospital, it is highly essential that the board concerned shall obtain the most expert advice possible, first, as to the desirability of proceeding with the building program and, second, as to the general size of the program and the general content of the building or buildings to be constructed.

In a few situations, a hospital's own administrator might be able to present an objective report of a study of these matters. In general, he is too busy with his regular administrative duties to undertake this responsibility and, in many instances, the administrator would be inexperienced in the conduct of the necessary surveys. In such event, the employment of a suitably qualified hospital consultant is the next step for the board to take.

The essential qualifications of a hospital consultant have never been thoroughly defined. He is usually a person engaged in the active administration of a hospital, or previously engaged in such work, who, through study and experience, has developed particular ability in studying hospital requirements and translating them into building plans.

Persons of other types of background have sometimes been successful as hospital consultants but, in most cases, the proficiency of the consultant can be traced back to active experience in the administration and detailed operation of a hospital as a going concern.

A hospital board, in seeking a consultant, could ask the advice of authoritative hospital organizations, of editors of hospital journals or of other hospitals known to have employed consultants.

The consultant alone, or with the aid of members of his staff, will study the community picture in relation to the proposed hospital development and, of course, will carefully study the needs and potentialities of the existing institution. State, regional and city planning data should be considered when available and, if reports are available from central bodies relating particularly to hospital developments, they will, of course, be utilized.

The consultant may decide that the proposed building project is unnecessary. In completely preventing ill-advised hospital construction, a consultant provides a valuable service. He should be encouraged to be entirely objective in presenting his conclusions upon this point.

If the consultant concurs in the need for construction, his report should outline in considerable detail the number of beds, their distribution and class of accommodation and the age, sex and medical classification of patients. He must designate what auxiliary and specialized facilities the particular building will need to provide, not only for the new beds that may be added to an existing plant but for a suitable rounding out of the service of the hospital as a whole.

Having in hand the well-considered report of a competent consultant, the board should proceed to employ the architect. In selecting its architect, the board will naturally want to review with care the past record of the particular firm as to general variety, volume and success of past work. It will be important to look into the financial responsibilities of architects under consideration and to make inquiry of other owners for whom they have worked as to each firm's reputation for honorable and truly helpful relationships with owners during the actual course of planning and construction.

It is important to know the degree to which the architect has cooperated helpfully with the owner during the entire project and to learn whether his supervision of the construction has been sufficiently painstaking.

The employer of an architect needs to know something about the individuals within the firm who will handle the particular job. Like all organizations, architects' offices have

been subject to changes in personnel and such changes are capable of affecting, one way or the other, the capability of the firm itself for carrying on a hospital project. It is always important to inquire about the qualifications of the architect's engineering staff or, if he uses a cooperating firm of engineers, to know its qualifications.

Written Agreement Desirable

When, after careful deliberation, an architect has been selected, the board should enter into a written agreement with him. This agreement must define, in detail, the responsibilities the architect is to assume, the method of determining the fees that are to be paid, the handling of extras, late revisions in plans and like matters.

The agreement should take cognizance of eventualities that could occur in connection with the project. For instance, should the plans be prepared but the building not be finally constructed according to those plans, there should be an understanding as to what the owner's obligation shall be. The extent of the supervision expected of the architect should be clearly defined.

A board that is inexperienced in such matters may well confer with other hospitals that have had such experience. Many potential arguments may be avoided by careful attention to the original agreement.

It is conceivable that the consultant who made the original survey as to the need of the construction project may not be available, or might not be qualified, to proceed as consultant to the owner and the architect in the development of the actual plans. In any case it is essential that such a consultant be employed by the board. His status in the entire project shall be clearly outlined to and established with the architect and with the consultant himself. A written agreement with the consultant is advisable.

At some point in the realization f a building project, the question of financing becomes a prime factor. In some projects, funds will already have been in the hands of the hospital to finance the work. Usually, the reverse will be the case and, following the preliminary planning of the proposed construction, the hospital board will want to undertake the raising of the necessary funds.

In such instances, it is quite usual for the board to authorize the architect and consultant to develop preliminary plans to a point at which rough estimates can be obtained on the probable cost of the proposed construction, basing the amount of money to be raised upon such estimates. At this juncture it is often desirable that the architect provide visualizations of approximately how the new construction will appear when completed. Such visualizations can be quite helpful in the raising of funds.

The raising of sufficient funds is obviously a *sine qua non* of the whole construction project. The best possible program of public relations must be formulated and launched preceding the fund-raising effort.

The board must not discount the necessity for an efficient, thorough and sufficiently aggressive money-raising effort. Expert consultation in fund raising is available and should be utilized to the extent to which the particular situation requires.

The actual planning will start, in any case, with preliminary sketches worked out by the architect in conjunction with the consultant. It will be necessary to hold conferences at frequent intervals among the architect, the building committee representing the owner, and the consultant. This group should expect to proceed slowly and conservatively, particularly in this early part of the planning.

There must be no hesitancy upon the part of any of the three agencies concerned to scrap a preliminary plan in favor of a better one. The more open-minded the group can be to new ideas in this stage of the planning, the better the end results.

When the general features of the plan have been agreed upon, the project will proceed with the development of closer details and will progressively get into finer and finer minutiae of the construction of the building and the placing of its built-in equipment.

Whether or not the architect and consultant are expected to plan and specify fully the movable equipment of the institution, it is imperative that they and the representatives of the hospital consider these matters in detail because of their importance to room sizes, wall spaces to accommodate furniture and like practical considerations.

At periodic intervals during the planning, and if necessary during the actual construction, the building committee should make it possible for the architect and the consultant to confer, as needed, with representatives of the medical and administrative staffs of the hospital in relation to details. Final decisions upon suggestions of these persons would, of course, be a function of the building committee.

When sufficient funds are available and plans have been completed, the next logical step will be to select the builders who are to undertake the construction. The architect is of invaluable aid to the building committee in considering this point. In many instances, a series of contractors, believed by the owner and architect to be capable, is asked to enter into competitive bidding for the construction contract or contracts.

Select Bidders With Care

If this method is used, it is most important that firms invited to bid be selected with greatest care as to their ability, integrity and past record of accomplishment. In many instances, hospitals have found it desirable to select a builder of superior qualifications and commission him, through subcontracts with the various trades, to construct the building for its actual cost plus an overall percentage fee to the building firm.

Architectural plans and detailed specifications may have been executed to a nicety and a presumably satisfactory contractor engaged, yet, even then, the owner must see to it that those plans and specifications are carried out to the letter.

In large projects it is common to have an inspector or clerk-of-the-works on the job, not as an employe of the contractor but representing the owner and architect. His main function is to see that the plans and especially the specifications are carried out to the letter—in other words, that the owner get his money's worth.

The diagram that accompanies this article undertakes to depict in graphic form the groups and the individuals that will be necessary to the successful realization of the project and, at either side, lists specialized groups and individuals that will be interested in the planning and whose cooperation and assistance will be essential to its success.

VALLEJO COMMUNITY HOSPITAL

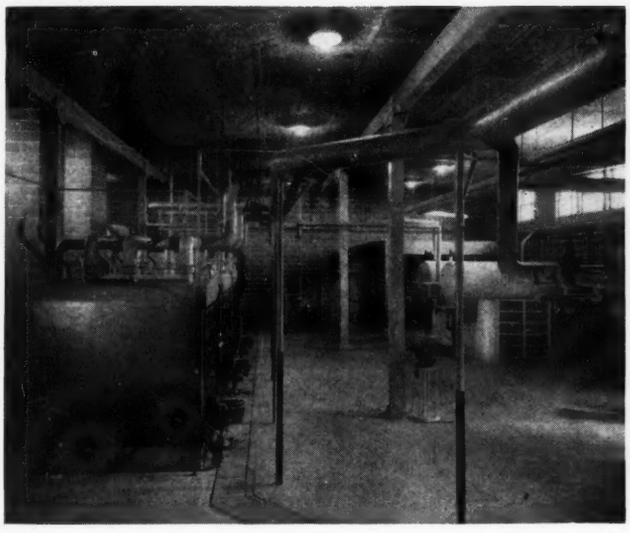
VALLEJO, CALIF.

DOUGLAS D. STONE AND LOU B. MULLOY

ARCHITECTS, SAN FRANCISCO

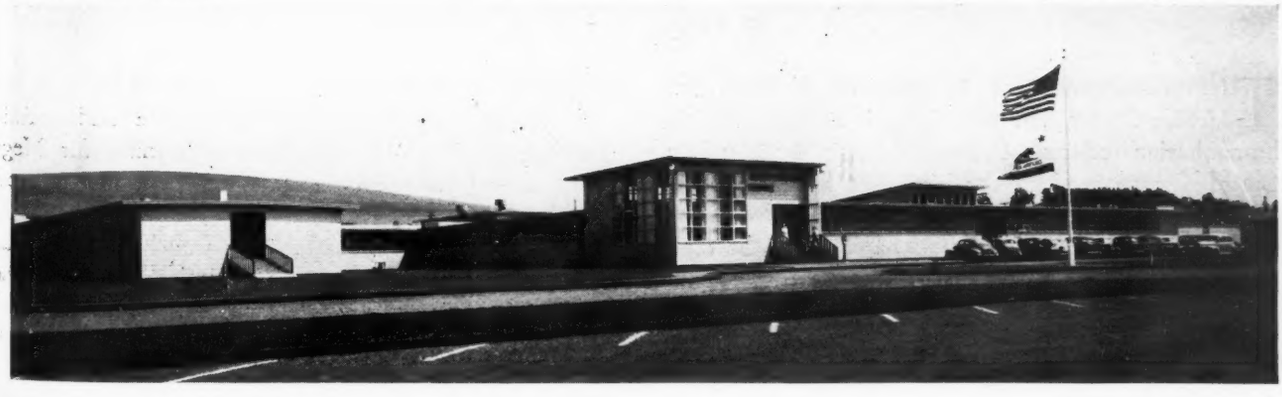
This 250 bed community hospital was designed to fill the needs of a small California town, the home of Mare Island Navy Yard, which in less than two years quadrupled its population—from 25,000 to 100,000. The institution, constructed with Lanham Act funds, is of one story construction and is located on a 20 acre tract about three miles from the center of the city. It offers all the usual facilities found in a hospital, with special provisions for maternity, pediatrics, psychiatric patients and a section for communicable disease cases

BOILER PLANT—BLOCK 2

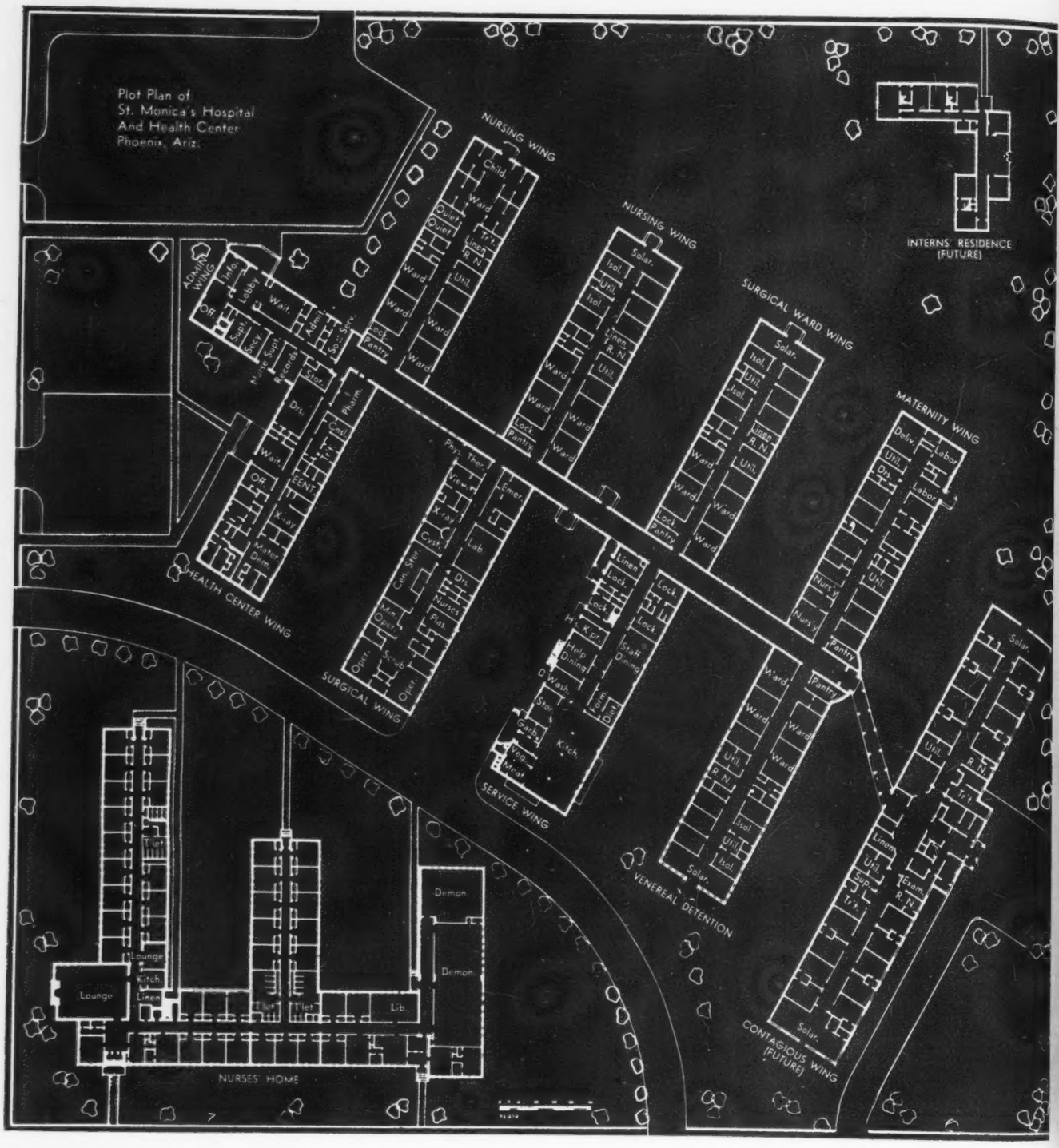


MAIN KITCHEN—BLOCK 2

GENERAL VIEW—BLOCK 1



THEY NEEDED IT "SOUTH OF THE TRACKS"

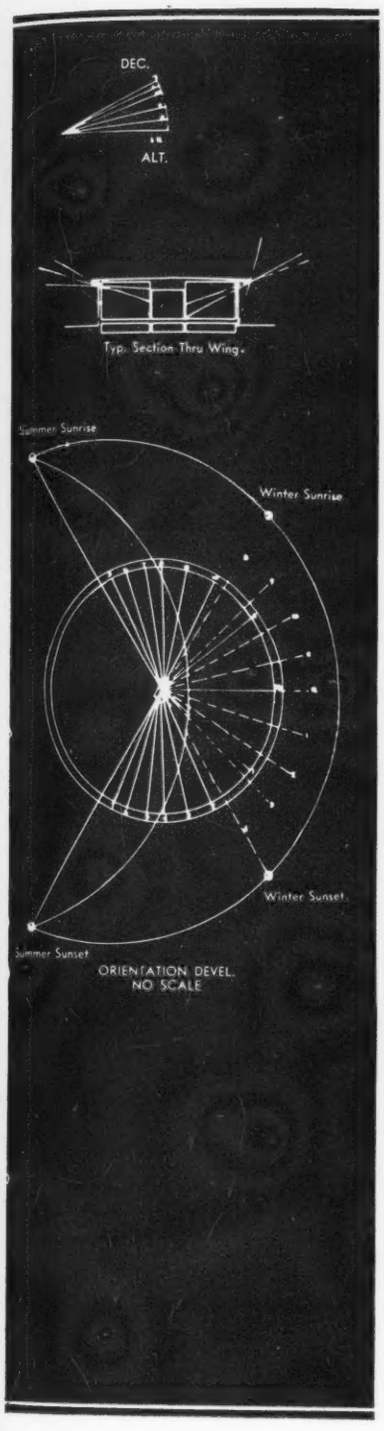


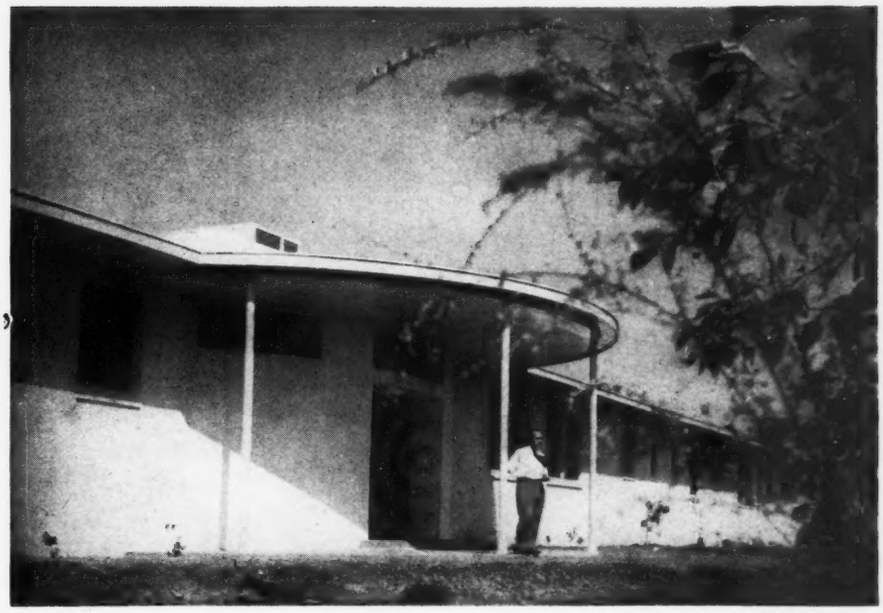
THE development of St. Monica's Hospital and Health Center, Phoenix, Ariz., is built around the humanitarian efforts of Rev. Emmett McLoughlin, O.F.M., who conceived the idea of a hospital located "south of the tracks" for the benefit of those people who would not or could not afford to go to the other hospitals of the city.

Through the cooperation of the U. S. Public Health Service and the Federal Works Agency, a grant was approved by the President for $490,000 covering the construction of a 150 bed acute general hospital with out-patient department, nurses' home and training school. This school will provide training for Negro, Indian and Latin-American women, not now accepted by most hospitals of the nation.

Phoenix lies approximately on parallel 33°, 30 minutes north latitude and in a semi-tropical climate; the thermometer in summer constantly hits 110°F., with a relative humidity of from 40 to 50 per cent, and the winter temperature is mild, averaging 70°F. during the day.

LESCHER and MAHONEY
Architects, Phoenix, Ariz.





ABOVE: View in the entrance to the office showing the use of redwood for wainscot and trim. BELOW: Doors and entrance area at south end of the main hospital corridor. It will be noted from the plot plan and orientation development that the building has been placed off a due north and south line, being oriented 30° east of due north. This was done with a view to approaching as near an ideal exposure as possible.

The building is fully air conditioned and cooled for comfort during the hot summer months and is heated by means of a steam heating plant for the winter months.

The building was erected under war-time conditions with a consequent lack of many materials normally used in hospital construction, and the architects have had to use their ingenuity in many instances to keep the building within the regulations established by the War Production Board.

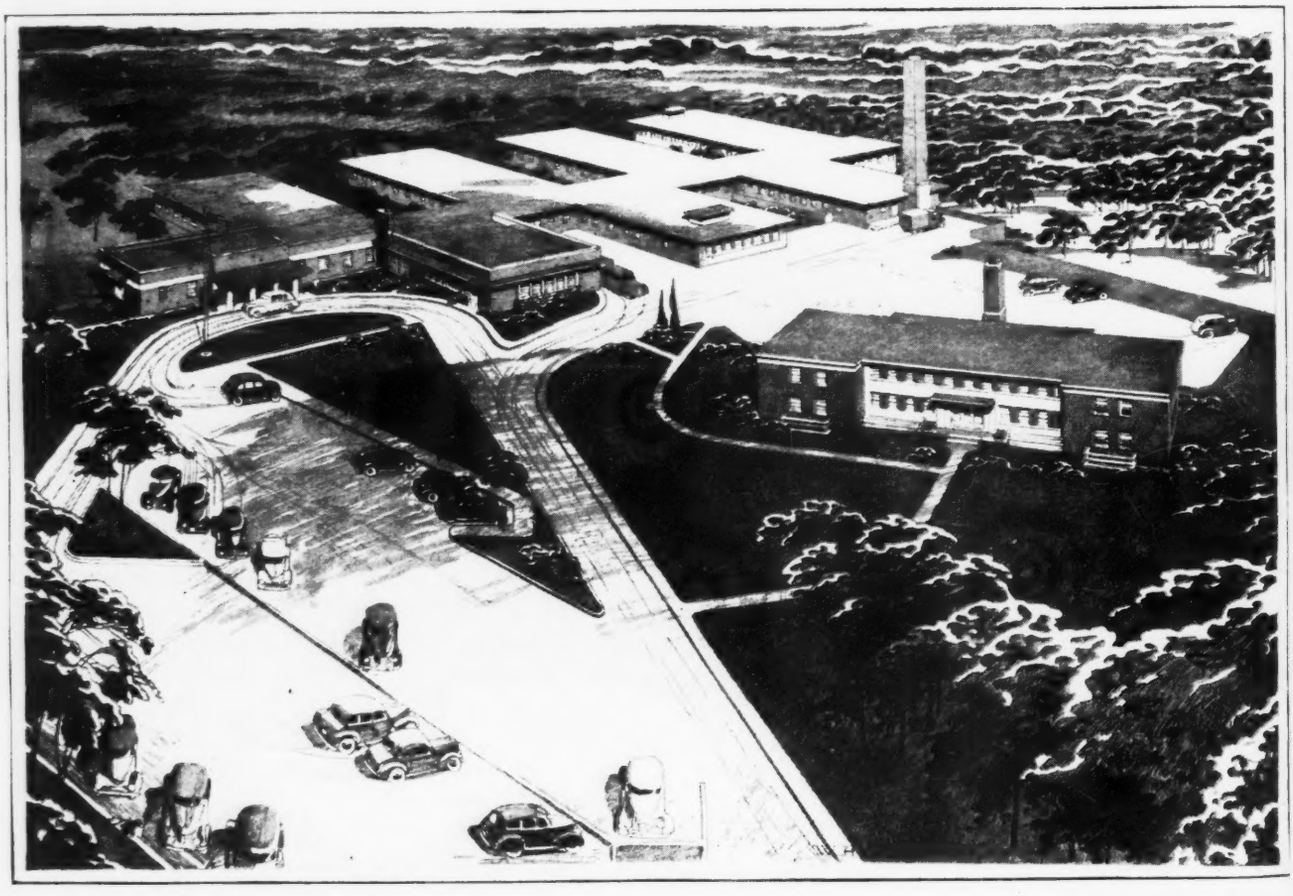
A study of the plan will indicate the various wings opening from the main corridor, the walls of which have been carried above the surrounding roof lines so as to provide a direct fire break between any two adjoining areas.

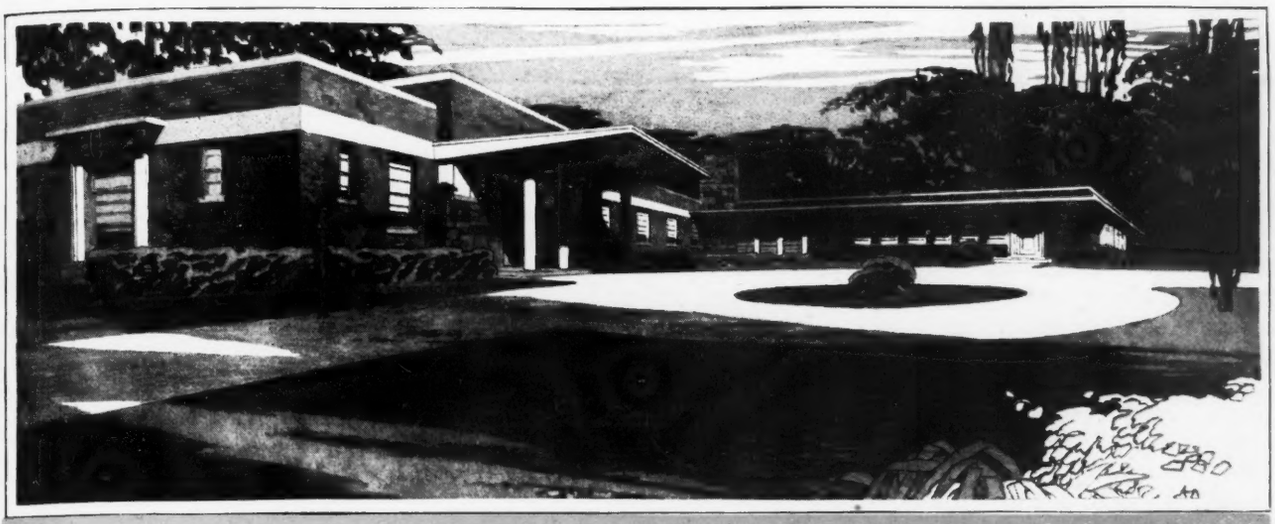
The construction was under the supervision of the emergency operations unit of the Public Buildings Administration, with Marshal Shaffer, chief architect, and Neil McDonald, consultant, Hospital Facilities Section, U.S.P.H.S., as planning consultants.

A 100 BED HOSPITAL HELPS TO EASE THE STRAIN IN WASHINGTON

The opening of Prince George's General Hospital, Cheverly, Md., one of three new suburban hospitals built with Lanham Act funds, has done much to relieve the critical shortage of hospital beds and facilities in the Washington metropolitan area. Built by the Public Buildings Administration, F. W.A., the hospital follows in general standard plans approved by the U. S. Public Health Service, but presents its own special architectural features and distinctive treatment

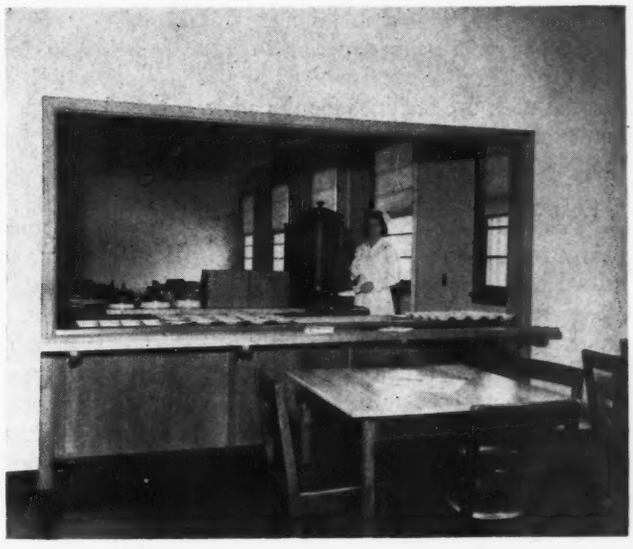
Federal Works Agency Photographs

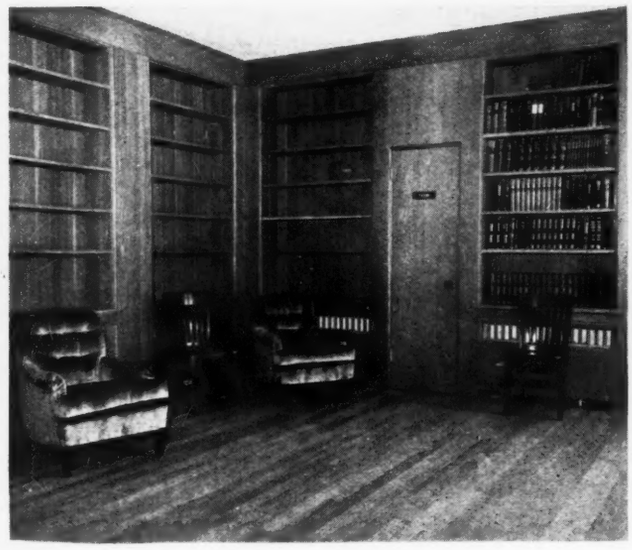




PRINCE GEORGE'S GENERAL HOSPITAL *KEA, ROSS & WALTON, ARCHITECT*

Opposite page (above): The nurses' lounge; (below) a general view of the hospital site. Above: Close-up of entrance. Below: Four interior shots showing the utility room and doctors' and nurses' cafeteria (top), doctors' lounge and a semiprivate room (bottom).





THE PUBLIC HEALTH CENTER AND THE COMMUNITY HOSPITAL

A NEW attitude toward public health is now being expressed by the American people. It might be termed "health consciousness." As the war has progressed this attitude has become more and more vocal. Today there is a demand on the part of the American people for more and better hospitals and health centers, for more equitable distribution of these facilities and for more doctors and nurses in public health, industry and rural areas.

Hospital administrators, boards of trustees and public health officials are responsive to this attitude of the public. They are conscious of the fact that their respective fields of responsibilities have broadened and, to some extent, merged. This realization is reflected by the current interest in a close correlation of the functions of a hospital with the facilities for the administration and practice of public health.

Kellogg and California Pioneer

Although the advantages to be gained by this coordinated effort on the part of hospitals and public health programs have been appreciated for some time, the development of the practice outside of metropolitan areas represents a relatively new trend of thought which has been pioneered largely by the W. K. Kellogg Foundation[1] and several counties in California.

Before any new development can be expected to gain public approval and support, its value and usefulness must be apparent. The values inherent in correlated hospital-health center activities are both tangible and intangible. The tangible values relate directly to the public point of view in health matters.

It is becoming increasingly difficult to distinguish between the so-called preventive and curative aspects of health, even by those engaged in these respective activities. The differentiation, for the most part, eludes the public. For this reason it is perfectly natural that a community should expect one establishment to provide all services pertaining to individual and collective health.

In addition to the advantages afforded the public by a centralized health service, both hospital and public health activities benefit by correlation. Public health attains stature and dignity. Better understanding and support on the part of the public are promoted when a larger segment of the population becomes familiar with the sources and objectives of public health programs. The public health officer benefits professionally by a closer association with clinical medicine and hospital practice.

Through the correlation of activities, the hospital can offer a more comprehensive type of service and its staff will benefit from a closer association with public health problems. Another intangible value is the education of the public in the services offered by hospitals. Even in metropolitan communities many people still have a marked aversion to entering a hospital and do so only as a last resort. In rural areas this attitude is even more marked.

An arrangement that will introduce more people to the hospital atmosphere will stimulate public interest and support. And widespread public interest and support constitute the life blood of the community hospital.

The tangible values inherent in correlated public health and hospital activities are perhaps even more apparent. When public health was young and its functions were mainly the enforcement of sanitary ordinances, little was required in the way of facilities except simple desk space, and this was usually in the least desirable public quarters available.

As the science and the concept of public health have developed and broadened, the need for more space and more complex and expensive equipment has grown accordingly. The war has been an additional factor in this acceleration. It has multiplied health problems and at the same time depleted public health personnel so that the inadequacies in public health facilities in common with other health and hospital facilities have been brought sharply into focus.

During the last two years a considerable number of community health centers, modern in design and equipment, have been built with federal assistance.[2] Now that a pattern has been established and the value of modern health facilities demonstrated, it is certain that the nation is entering a new era of public health practice.

This new era introduces a problem of considerable social and economic importance, a problem that must be met by the state and local health officials and the directors and trustees of public and voluntary hospitals. Shall hospitals and public health services continue to go separate ways and duplicate within the same community expensive construction, equipment and personnel? Or shall they correlate their efforts wherever possible?

Costs Go Up, Too

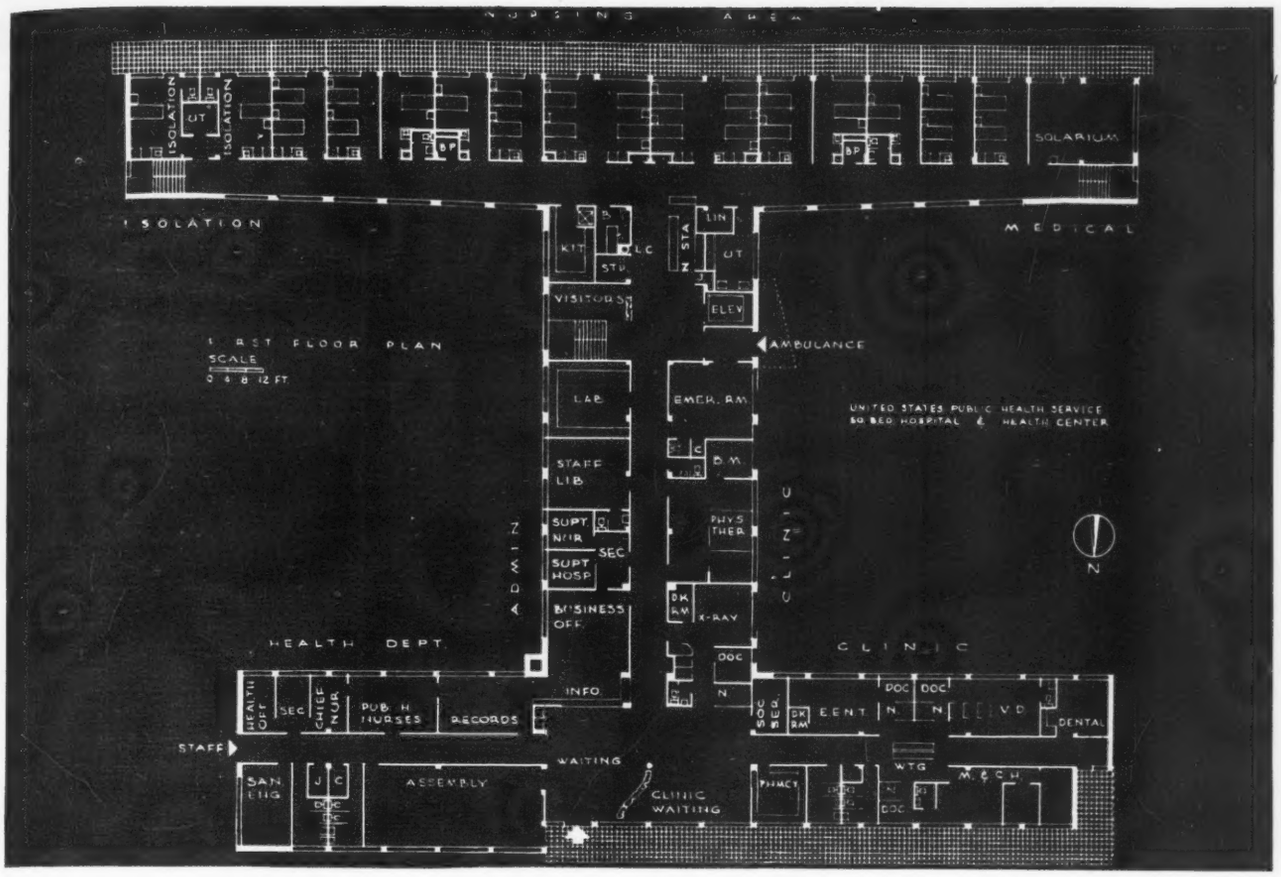
The rapidly increasing demand for health services of all kinds is accompanied by rapidly rising costs that threaten a wider distribution of these services. Every effort must be made to cut costs wherever possible. Elimination of duplication of facilities and personnel is one important means to this end.

Although the theory of public health-hospital cooperation is applicable everywhere, it is to be expected that the practice will vary considerably from place to place. In large urban centers, the population group is sufficiently large to permit a high degree of specialization in all health activities. Where this is true, there

VANE M. HOGE, M. D.
Senior Surgeon, Hospital Section
State Relations Division
United States Public Health Service

[1]Health Centers—Building Types. Architectural Record, 1940.

[2]Public Health Centers. Arch. Record, Building Types Study No. 67, July 1942.



is probably little or nothing to be gained from any joint usage of space, equipment or personnel by different organizations. It is in the communities in which the population groups are smaller and the necessity for economy is greater that a fuller integration of health facilities and services assumes the greatest significance.

There are now approximately 1835 full-time county and district public health organizations in operation throughout the country financed through federal, state and local funds. A majority are operating in inadequate and unsatisfactory quarters. In many of these health jurisdictions, and in those to be established, modern facilities will be provided. First-class hospitals, well staffed and equipped to assist in many of the more technical public health functions, already exist in many of these communities.

In other communities that have public health programs, no hospitals are to be found. These facilities will have to be provided in the near future. From the points of view of cost and efficiency, it is important that the so-called preventive and curative health measures be integrated as closely as possible. In the most isolated and sparsely populated areas there seems to be no alternative but to furnish some hospital care in health centers as a part of the public health program.

Plans are now being formulated by the American Public Health Association which, it is hoped, will result in public health services to all the counties of the nation.[3]

In the accompanying illustration an application of the principles under discussion is shown in the first floor plan of a 50 bed rural hospital. The public health facilities are an integral part of the hospital plan. Both the hospital features and the public health features are designed to serve a community of about 25,000.

One entire wing serves as administration space for the public health staff. The opposite clinic wing is designed primarily to accommodate the type of clinic ordinarily conducted by public health departments. The same space is also usable for such out-patient work as the hospital may see fit to carry on.

The diagnostic facilities shown in the central wing, although perhaps serving the hospital patient primarily, are nevertheless readily available for use by the public health department.

This plan is presented for the purpose of illustrating the principles of correlated public health and hospital facilities. In the application of this principle, considerable latitude would be not only permissible but also desirable in accommodating to local conditions.

For example, public health administration space might be completely separated from the hospital proper so long as it remained conveniently adjacent. The actual physical arrangement is relatively unimportant if it is convenient and permits the fullest common usage of space, equipment and personnel.

It is not intended that hospitals should absorb public health activities or that public health should assume the responsibilities of the hospital. On the contrary, it is clearly recognized that each has its special function in the community. It is to be hoped, however, that in the future there will be a closer alignment of effort to the end that the dollars spent for health will give the greatest possible return in social and scientific values.

[3]Am. J. Pub. Health, April 1943.

AVOID THESE ERRORS

TO GUIDE hospital administrators, trustees and architects, The MODERN HOSPITAL asked a few leading architects and consultants to list the most frequent and important errors they had observed in the planning of hospital buildings. Although there is much agreement in the answers, each authority presents somewhat different points.

PERRY W. SWERN
Hospital Architect, Chicago

Most of the troubles in hospital planning by architects who are not experienced in this type of building are due to the fact that the general practicing architect undertakes to plan a building to house an organization whose functions he does not clearly understand. He then selects various parts of buildings that appeal to him, quite frequently from plans published in your magazine, and attempts to put these parts together like a patchwork quilt.

The circulation and functions of the various departments are not understood and are therefore clumsily handled. The resulting lost motion causes most of the trouble.

CHARLES F. NEERGAARD
Hospital Consultant, New York

A hospital is the most complicated type of modern building. Its requirements are in a constant state of evolution and growth. Its many functions and departments must be in proper balance and relationship to one another if it is to operate economically. Many people with varied backgrounds, objectives and ambitions have a voice in its planning, rarely with the perspective that enables them to adopt the sound improvements and avoid the mistakes that have been made elsewhere.

My list of major errors follows:

1. *Lack of over-all community planning.* This frequently results in extravagant duplication and overlapping.

2. *Failure to anticipate future expansion.* Perhaps the commonest problem is to unscramble and enlarge a hospital that has added beds without increasing its service units. Every hospital should start with a basic plan so that beds can be added and departments expanded without destroying proper balance and interrelationships.

3. *Failure to provide flexibility.* Flexibility is the most valuable and most commonly neglected asset in the hospital plan. Rarely in a normal year is every bed filled; there are constant fluctuations, in good times and bad, in the demands for ward, semiprivate and private beds in the different services. Many poorly conceived hospitals have an average occupancy of but 66 per cent, thus maintaining three beds for each two patients. The flexible plan, which has a practical occupancy of from 80 to 85 per cent, requires only five beds for each four patients.

A hospital designed for an average load of 100 patients, with 66 per cent occupancy, would need 150 beds but at 80 per cent occupancy would need only 125. At a capital cost of $5000 per bed, the flexible plan saves $125,000 in the investment and $17,500 a year in overhead, allowing $700 a bed a year for readiness-to-serve costs, interest and depreciation.

4. *Failure to build in operating economy.* This error can be obviated by eliminating waste motion and budgeting space so that each department and room will be just large enough, with a little leeway for adding new equipment later. Failure to adopt efficiency measures will increase the budget many thousands a year.

5. *Handicaps in patients' quarters.* These include: nursing units too small for economical service and control; inadequate utilities, inconveniently located; excessive provision of private baths and toilets; omission of running water in rooms and wards; no nurses' restroom, visitors' room or flower room.

In one large institution, the city's "last word," 16 errors and extravagances were noted in and about one private room. The full list of errors in this unit will be found in The MODERN HOSPITAL, August 1936, pages 67-68.

6. *Extravagances and misconceptions in the mechanical plant.* Frequently, we find factors of safety, breakdown reserves, automatic controls and refinements that are greatly exaggerated. The most important is overheating. The hospital neither needs nor can afford much that engineers provide.

Approximately 30 per cent of the building investment is in the engineer's province. Basic extravagance in the plans is not easy to remedy. Continuing maintenance is the plant problem. Commonly, two high-pressure boilers are installed, each large enough to meet maximum winter needs. As but 20 per cent of the load requires high-pressure steam, summer operation is extravagant. Two smaller high-pressure boilers and one low-pressure boiler would be flexible, efficient and economical.

Kitchen and laundry equipment often are out of balance and improperly sized for the load; this results in bottlenecks slowing up the entire plant, increasing operating hours or requiring additional help.

The engineering budgets for power, light and heat of 16 hospitals studied show a startling range from $32 to $260 per bed per year. The lowest figure was in Canada, where extreme winter temperatures and coal costing $14 a ton would justify the highest but the design combined a highly efficient hot water heating plant with thorough insulation of the building.

7. *Failure to insulate walls, roofs and windows.* This is almost universal. Yet in my experience from 80 to 90 per cent of the additional structural cost for insulated walls and double glazing is offset by savings of some 50 per cent in the size of radiation and boilers. A more important point is that insulation cuts in half the *annual* expense for heating for the life of the building and in summer the indoor temperatures average some eight degrees cooler.

8. *Failure to control noise.* A noisy hospital is inexcusable but, oh, how common! Peace and quiet are priceless for the patient and can be built into the structure at little cost. Acoustical treatment in noisy places, soundproof partitions, antivibration insulation of machinery, noiseless switches, hardware and plumbing are practical and reasonable.

9. *Haphazard planning.* The most complex building in the community is all too often planned and built in a haphazard fashion. Many errors could be avoided, given an experienced planning group—architect, engineer and consultant—each knowing in his own field what a modern hospital should be, coordinating and guiding the ideas and interests of the hospital family to the end that the building shall combine the practical and economical with the beautiful.

WILLIAM A. RILEY
Hospital Architect, Boston

The most frequent and significant errors I have encountered are:

1. *Lack of careful survey.* Many hospitals fail to have a comprehensive survey to reveal the actual conditions and real needs for expansion. The survey should be made before any working drawings are done and should include the following:

A study of the past history of the hospital to form a basis for judging future trends.

Consideration for the proper balance between patients' accommodations, potential income and operating costs of all departments.

Determination of the number of additional beds needed in the community for a period of at least fifteen years and the probable needs for increased facilities for all departments.

Breakdown of approximate costs of construction on a step-by-step program to permit portions of the expansion program to be carried out as funds permit.

These studies should be based upon the results of conferences with trustees, appropriate committees, the administrator and all of the department heads.

2. *General planning failures.* A few of the most frequent of these are:

Lack of vision in any rehabilitation or expansion program.

Failure to adhere to a program once established and worked out.

Failure to recognize and eliminate errors made in the past.

Improper location of buildings in relation to one another and in relation to future expansion.

Insufficient time given to the development of working drawings, specifications and details to assure completeness.

Failure to appreciate that first costs are not as vital as maintenance costs.

Failure to place in the hands of department heads thoroughly studied preliminary drawings that would permit the assembling of all comments for constructive criticism.

Insufficient study made of units that are repeated many times in the program, such as typical patients' rooms and operating units.

3. *Structural and detail planning errors.* The most significant errors observed in visits to hospitals, both old and new, are:

Doors not properly designed for hospital purposes.

Elevators insufficient in number and not large enough for hospital use.

Nurseries not properly planned for modern technics of baby care.

Stairs not properly located for safety and accessibility to other floors.

Unwillingness to sacrifice symmetry in design where required for best hospital planning.

Inadequate acoustical treatment.

Details not kept to simple lines for economical maintenance.

Floor materials not properly designed for particular requirements, such as excessive traffic wear and resiliency where necessary to relieve fatigue.

Improper heating and plumbing equipment; not studied by capable engineers to ensure practical efficiency and economy.

Failure to recognize the need for centralization of certain departments, *e.g.* central preparation rooms, central storage rooms.

Failure to provide economical nursing units with the proper segregation of patients' facilities.

Lack of flexibility for expansion possibilities essential in medical departments because of progressive improvements in technics.

Inadequate space in patients' and other rooms for essential built-in and movable equipment.

Poor judgment in selection of hospital site that is inaccessible, difficult to approach or without proper space for the inevitable expansion.

Failure to appreciate that some older hospitals have spent their life and could better be removed than rehabilitated.

CHARLES E. REMY, M. D.
Hospital Consultant, Chicago

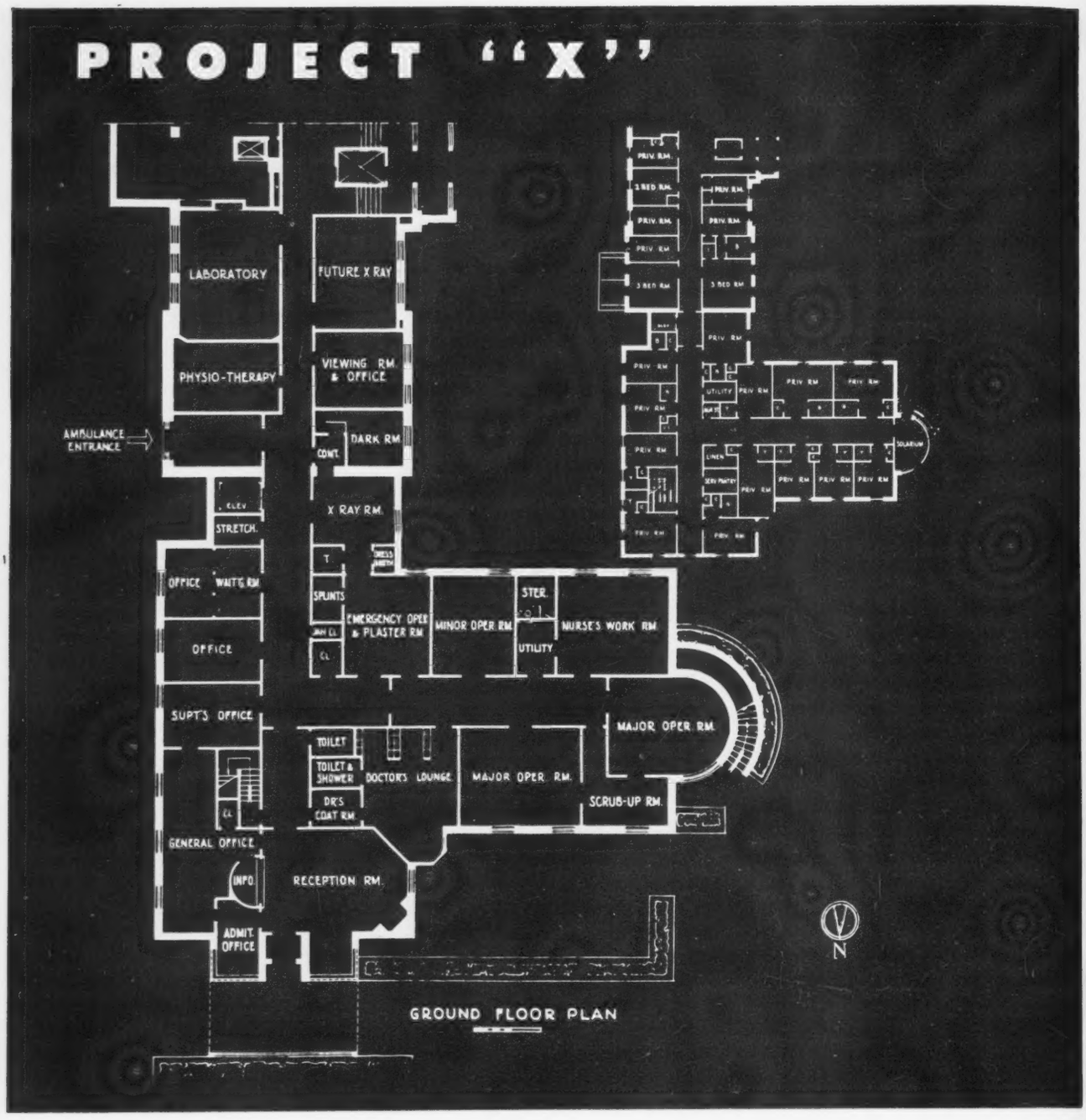
1. The most frequently encountered defect in hospital construction is the custom of building an attractive structure and attempting to force or squeeze or hammer the various hospital departments into the quarters set aside for them, regardless of the adequacy of such quarters.

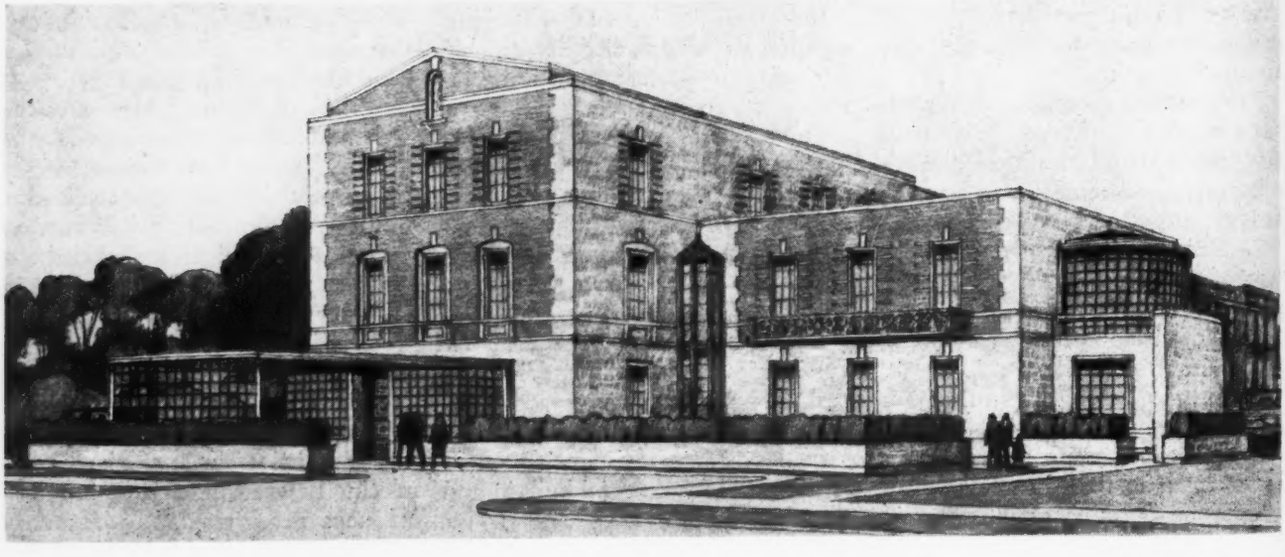
2. Within the last thirty days, I have inspected at least six hospitals with corridors varying from 3 feet 10 inches to 5 feet in width. The inadequacy and inconvenience of such narrow corridors are well known to every administrator. Yet we find this mistake made repeatedly.

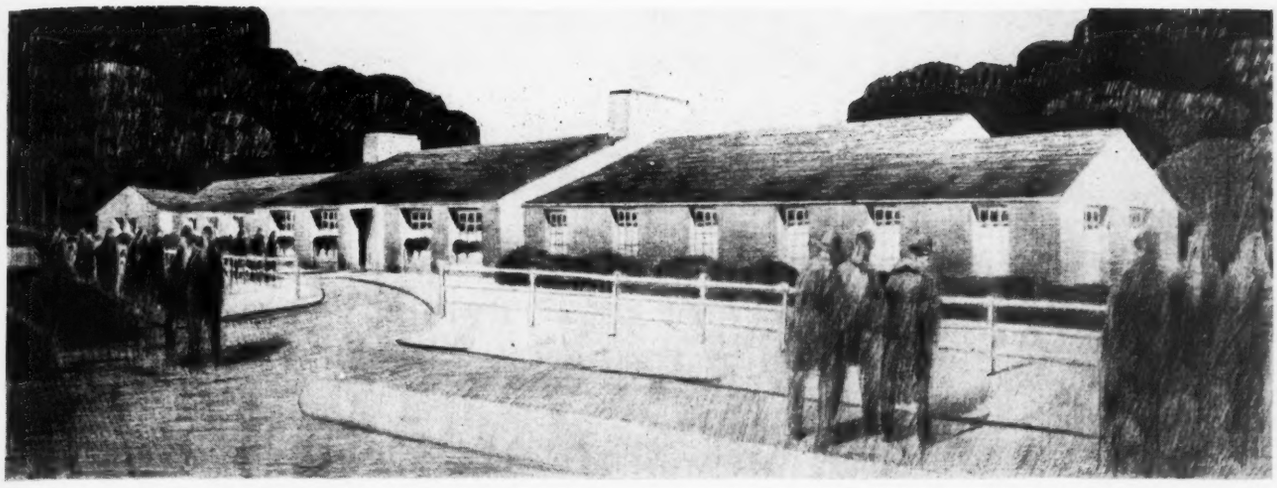
3. Recently, an administrator told me his hospital was planning to spend several thousand dollars just to widen patient room doors. And yet, 3 foot doors are still being installed in hospitals!

4. In a recent hospital survey we found no provision whatever for food service on the patient floors. Trays were sent up in a dumb-waiter and were placed on the floor of the corridor until a nurse or maid took them to the patients. We constantly encounter inadequate and poorly planned food service accommodations on patient floors. We often find dumb-waiters opening into main corridors instead of into the floor food service kitchen.

5. One of the most vicious errors is the underprovision of service facilities as compared to patient rooms. Frequently, inexperienced architects or trustees erroneously believe that utility rooms and floor diet kitchens may be put into whatever space is left after all desirable space has been divided into patient rooms. The result: utility rooms and diet kitchens in misshapen, dark corners without windows or adequate ventilation. Another point often overlooked in placing these facilities is the number of steps necessitated for the nurse.


PROJECT "X"
LABORATORY
FUTURE X RAY
PHYSIO-THERAPY
VIEWING RM. & OFFICE
AMBULANCE ENTRANCE
DARK RM.
CONT.
X RAY RM.
STRETCH.
OFFICE
WAITG. RM.
OFFICE
SUPT'S OFFICE
GENERAL OFFICE
INFO.
RECEPTION RM.
ADMIT. OFFICE
SPLINTS
EMERGENCY OPER. & PLASTER RM.
MINOR OPER. RM.
STER.
UTILITY
NURSE'S WORK RM.
MAJOR OPER. RM.
SCRUB-UP RM.
TOILET
TOILET & SHOWER
DOCTOR'S LOUNGE
DR'S COAT RM.
MAJOR OPER. RM.
PRIV. RM.
3 BED RM.
UTILITY
LINEN
SOLARIUM
GROUND FLOOR PLAN



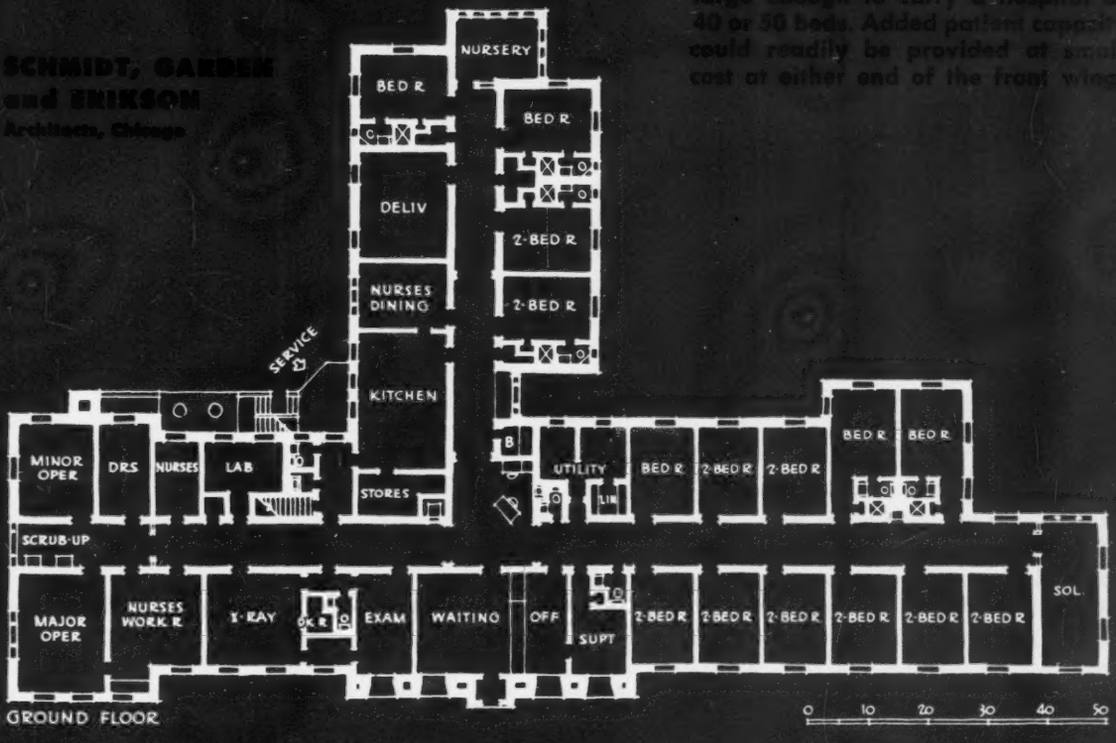


PROJECT "Z"

Opposite page: Project "Z" is an addition to an overcrowded 55 bed general hospital that will provide 46 beds, as well as operating suite, x-ray department, laboratory, business offices and physical medicine rooms. The addition is put on at the back of the existing hospital where the ground falls away; hence the ground floor is all above grade although it is level with the basement of the old building. The second floor of the addition (not shown) is devoted to rooms for private patients with exception of one three bed room.

Project "Z" is a 25 bed general hospital in a community of 4500 which is from 10 to 19 miles from the nearest hospitals in any direction. There is a part basement for boiler room and storage. The outside is of brick and the building is of fireproof construction throughout. Estimated cost under present conditions in the Middle West would be about $125,000, or $5000 per bed. Note the segregation of the maternity wing at the top of the plan; the two bed room on the right can be included in the maternity department or excluded at will by means of two doors in the corridor. Thus, the maternity department may contain four or six beds as needed. The service unit of this hospital is large enough to carry a hospital of 40 or 50 beds. Added patient capacity could readily be provided at small cost at either end of the front wing.

SCHMIDT, GARDEN and ERIKSON
Architects, Chicago



GROUND FLOOR

NEW MATERIALS

A CHALLENGE AND AN OPPORTUNITY TO THE PLANNER OF TOMORROW'S HOSPITAL

ALEXANDER ROBINSON
Architect, Cleveland

WE HAVE come a long way through past depression and war years from the elaborate and overornamented type of hospital buildings. The colonnades, the ornamental cupolas, the unnecessarily thick walls, the expensive materials and frills have of necessity given way to fundamental good sense in the choice of materials. The tried and tested materials that last out the life of a building are what are needed.

Today, all of us are conscious of the promise and hope for new materials and new developments and technics, many of them so alluringly spread before the public and the building trades in advertising and magazine articles.

Common Sense Returns

There has been a recent recession in the wave of postwar ballyhoo that shows that common sense is reasserting itself.

The architects—at least those who have lived through the experience of trying out new materials and gadgets on their clients without proper preliminary testing—are stating what history has shown to be eminently true, that fundamental changes in types of materials are of necessity slow and tedious and that in public buildings, particularly, and more especially in those built to alleviate human suffering no chances can be taken that will impair the practical and long-time usefulness of the building.

However, there is another side to the choice of materials and the design of hospital buildings that cautions us against overelaboration and experimentation. Medicine is developing so rapidly and is opening up such new and constantly changing fields of activity that the hospitals we plan today may be useless tomorrow unless we keep them simple enough and direct enough in their planning so as not to be limited or spoiled by fads and cures that have but a brief span of usefulness in the march of medical science towards the ever-widening horizons of knowledge in this field.

What then are some of the fundamental standards and criteria by which we judge the materials that we incorporate in a hospital building?

1. Most important of all, they must be sanitary, therefore nonporous as far as possible, and, above all, easily cleaned. No building, not even the most meticulously cared for home, is subject to such thorough cleaning and scrubbing as is a hospital. Poor choice of materials shows up here faster than anywhere else.

2. Materials must be durable and of low repair and replacement cost. A shabby hospital is not only unattractive but insanitary and therefore a definite handicap in the treatment of the ill. Ease of maintenance and quick replacement speak well for good planning.

3. The equipment must be reliable and must operate with the maximum of efficiency. Untried equipment or fancy or complicated arrangements of plumbing, wiring or heating only lead to difficulties in operation and maintenance; and an unworkable piece of equipment is worse than useless—it is dangerous. Where human lives are at stake one cannot take chances with the failure of a piece of machinery.

4. All materials and equipment must be judged most carefully by the criterion of elimination of unnecessary noise. Noises within a hospital are much more disturbing to a patient than are outside noises. When one is ill every squeak or bang or roaring of air is a strain on the nervous system and care must be taken to reduce each of these as much as possible.

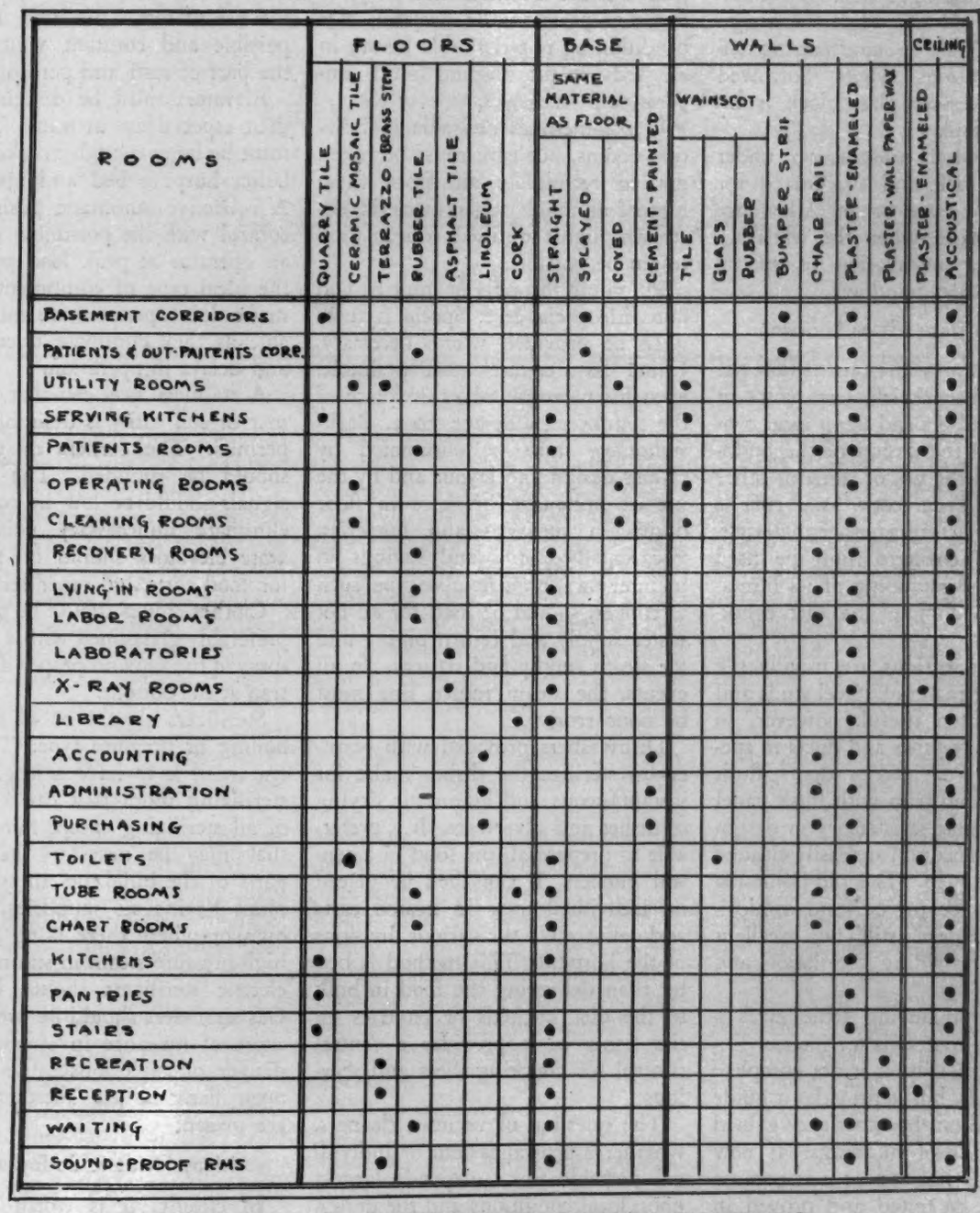
Appearances Do Count

5. With all these standards we must not forget the appearance of the building both inside and out. Here, materials must be chosen with care to produce attractive results with the minimum of elaboration. It is possible through the proper use of materials and color to produce cheerful and home-like surroundings in which to grow well and strong and yet not sacrifice economy or durability.

6. The materials must be economical both in use and in durability. First cost is not the final standard of judgment.

Now having set up a sort of table of standards let us look at some of the detailed uses of materials that have been found through use and experience to have stood the test of time.

One of the first considerations is that of the frame or structure of the building. Here the number of stories immediately conditions the



ROOMS	FLOORS							BASE				WALLS							CEILING	
								SAME MATERIAL AS FLOOR				WAINSCOT								
	QUARRY TILE	CERAMIC MOSAIC TILE	TERRAZZO - BRASS STRIP	RUBBER TILE	ASPHALT TILE	LINOLEUM	CORK	STRAIGHT	SPLAYED	COVED	CEMENT - PAINTED	TILE	GLASS	RUBBER	BUMPER STRIP	CHAIR RAIL	PLASTER - ENAMELED	PLASTER - WALL PAPER WAX	PLASTER - ENAMELED	ACCOUSTICAL
BASEMENT CORRIDORS	●								●						●		●			●
PATIENTS & OUT-PATIENTS CORR.				●					●						●		●			●
UTILITY ROOMS		●	●							●		●					●			●
SERVING KITCHENS	●							●				●					●			●
PATIENTS ROOMS				●				●								●	●		●	
OPERATING ROOMS		●								●		●					●			●
CLEANING ROOMS		●								●		●					●			●
RECOVERY ROOMS				●				●								●	●			●
LYING-IN ROOMS				●				●								●	●			●
LABOR ROOMS				●				●								●	●			●
LABORATORIES					●			●									●			●
X-RAY ROOMS					●			●									●		●	
LIBRARY							●	●									●			●
ACCOUNTING						●					●					●	●			●
ADMINISTRATION						●					●					●	●			●
PURCHASING						●					●					●	●			●
TOILETS		●						●					●				●		●	
TUBE ROOMS				●			●	●								●	●			●
CHART ROOMS				●				●								●	●			●
KITCHENS	●							●									●			●
PANTRIES	●							●									●			●
STAIRS	●							●									●			●
RECREATION			●					●										●		●
RECEPTION			●					●										●	●	
WAITING				●				●								●	●	●		
SOUND-PROOF RMS			●					●									●			●

TABLE OF SUGGESTED ROOM FINISHES

answer. For low buildings up to three floors in height reenforced concrete is often the most economical and simple in design.

For buildings over that height steel frame enters into the picture, and we are then faced with the question of riveting or welding the structure. Welding, because of the absence of noise, is particularly necessary for additions to existing buildings or for new buildings in a group already occupied. However, local conditions and union rules do not always permit field welding and we would have to fall back on the usual riveted frame.

For the floor system either a tin pan or concrete joists with tile fillers are best. The latter allow for the installation of piping later. Duct work should be in vertical chases that can also provide space for piping and the horizontal runs should be in furred spaces with adequate access doors or panels.

The best all-round windows are wood double-hung with pivot features for the ease of cleaning and ventilation. A wood sash provides

better insulation and the lack of condensation makes it preferable to steel sash. Glass block may be used in cases when light without ventilation is desired and when the design permits. Also, in constructing interior partitions where borrowed light is necessary glass block is extremely useful.

For spandrel construction under windows brick and tile furred for waterproofing are usual. Allowance must be made, when the walls are thinner, for installation of special radiators under windows.

Choice Depends on Location

For exterior wall construction the choice between brick, terra cotta or concrete will depend upon local conditions and the design of the building, as will the use of stone or other materials. Terra cotta as a rule is not as satisfactory as other materials. Reenforced concrete must be used with an understanding of its limitations as to climate and dirt conditions.

Interior partitions are usually tile or a similar material. Steel studs and lath are often useful, however, to accommodate pipes and ducts in special cases. For interior doors, flush steel buck and trim with flush panel doors are most satisfactory in design and appearance and are easily cleaned and maintained. The old-fashioned flap doors for private and semiprivate rooms are still an excellent means of providing ventilation and privacy.

The accompanying table gives a selection of materials for interior finishes. Necessarily, it is not complete in all details, but it provides a guide and is based on the experience gained in a number of buildings. If new materials do not appear it is because they must be tested and proved in actual use before an architect dares use them in buildings as important as hospitals.

For heating systems vapor or low-pressure steam is preferable. Direct radiation is most easily cleaned. If convector type of radiation is used, the radiators must have fronts that can be easily removed for cleaning. A weatherstat to anticipate temperature changes is most desirable to prevent overheating or underheating in climates in which there are likely to be rapid changes in the weather. Zone controls are necessary for rooms in wings having different exposures and should certainly be used in special rooms, such as the maternity wing or nurseries, where higher temperatures are desirable than they are in other parts of the hospital. Air conditioning is a desirable luxury in all parts of the hospital but is imperative in surgeries.

It is sometimes desirable in isolation rooms, but care must be taken not to recirculate air from these rooms, although when bacteria destroying lights are used, recirculation might be possible.

Plumbing throughout must be laid out with special care. Special fixtures must be provided where necessary. China fixtures are most desirable, even for necropsy tables, in place of the commoner alberene stone. Backsiphonage must be eliminated by proper design and layout and by the use of siphonage breakers in floor drains in surgeries and nurseries. For supereconomy and savings in maintenance, noncorrosive pipe, such as copper, should be used for all hot water supply and return piping and for steam supply and returns. In all events, the steam return line must be noncorrosive.

Dishwashers provided with boosters to sterilize the dishes make for instantaneous and automatic drying of dishes and silverware. It is preferable to prepare all the food in a central kitchen. It can then be placed on individual trays in heated carts and delivered to the various divisions of the hospital. This method is better than delivering the food in bulk to the diet kitchens or pantries on the floors as it provides a central control for checking diets and servings.

The question of vacuum cleaners, whether a central system or individual portable units, depends largely upon local conditions and the design of the hospital.

Proper communications, telephones, nurses' and doctors' calls and patients' signals must be provided. A doctors' "in and out" and paging system is desirable. If possible, provision should be made for telephone jacks for bedside telephones for patients. Radio outlets of the same sort are valuable and provide proper entertainment for the patients. A pneumatic tube delivery system is advisable for use among different departments, records rooms, nurses' stations and administrative offices.

The question of fire protection is largely one of proper construction and equipment. The best protection is fireproof construction throughout, the use of metal furniture as far as possible and constant vigilance on the part of staff and personnel.

Elevators must be designed with their especial use in mind. The cars must be large enough to take a regulation hospital bed and attendants. A collective automatic push button control with the possibility of using an operator at peak load periods is the ideal type of equipment. Automatic door operators are most desirable as they eliminate uncertainties and delays in operation.

A stainless steel cab that will not mar or soil easily is desirable if cost permits. The corners of the cabs should be rounded. The elevator signals should be low in volume to eliminate unnecessary noise. Separate elevators should be provided for food carts and other services.

Clothes chutes should be provided, preferably glass-lined with a flushing spray at the top and proper drain and trap at the bottom.

Sterilizers should be of the nonboiling or pressure type. The present trend is to have a large central sterilizing room that can take care of all sterilizing except minor items that may be necessary in various parts of the building. In small hospitals having no laundries of their own or where there is no need for high-pressure steam in summer time, electric sterilizers should be used. Gas sterilizers should be avoided because of nuisance in operation and danger of explosions caused by the open flame when anesthetic gases are present.

Many Fields to Be Explored

In closing, it is worth recalling that a hospital is one of the greatest challenges to an architect. There are fields of new materials and methods as yet unexplored. As an example, research into the uses of aluminum as a coming material for all sorts of structures and equipment has infinite possibilities. Its lightness and durability give promise of new forms.

Experience and judgment are necessary to evaluate the new as well as the old in materials and equipment in order that the buildings we erect shall keep pace with the ever-developing standards of medicine in America.

PERSONNEL MANAGEMENT *Comes of Age* in the hospital field

ALDEN B. MILLS

MANY hospitals are determined to "catch up" to the best practices in personnel management as found in progressive industries, well-managed civil service systems and government offices and the best community agencies. Hospital administrators and personnel managers realize now—quite keenly, in many instances—how far back in the procession hospitals are today. And even though there are some other enterprises that are even more backward, hospital administrators are not satisfied.

This is a conclusion that can justifiably be drawn from attendance and observation at the five day institute on hospital personnel management held at Yale University June 26 to 30.

They Asked for More

Evidence to support the conclusion includes:

1. The attendance of 116 students in the course representing 28 states and a high general level of competence (most of those attending were administrators or assistant administrators).

2. The high degree of interest manifested in spite of a grueling program running from 9 a.m. to 8:30 p.m. or later and during some of New Haven's hottest weather.

3. The firm determination to improve hospital personnel practices expressed by so many of those in attendance (over and over students stated that a hospital should pay the "going rate" in the community for work requiring similar ability, education, experience and working conditions).

4. The strong demand from the registrants that the institute should be repeated next year.

The faculty of the institute contained a good sprinkling of "big names" in the personnel management field. But even more important were the ideas expressed. This article will attempt to summarize some of them. Full proceedings will probably be published in due course.

The first thing needed in seeking a working force is to know exactly what you want, declared Lillian Gilbreth, noted personnel consultant of Montclair, N. J. This requires the development of job descriptions and personnel specifications (both of which must be kept up to date). These, of course, are based on job analyses and lead to job classifications and grading. Whoever is heading up this work must actually get out where the work is done and observe it.

The physical demands of various jobs should be carefully evaluated, Mrs. Gilbreth stated. A physical standards sheet for each job might list (a) physical demands (b) working conditions, (c) brief job descriptions and (d) safety measures to be observed. Many jobs can be filled excellently by crippled, blind or otherwise physically handicapped people. Sometimes a job can be divided to enable handicapped people to carry it adequately.

Physical conditioning and the intelligent use of body mechanics can be extremely helpful in improving the tone and output of a working force, Mrs. Gilbreth declared.

The fundamental qualification for any job is interest in that job, according to Howard L. Davis, vocational director of Brooklyn Polytechnic Institute and former personnel executive of American Telephone and Telegraph Company. An applicant for a job should have some interest in that job and he should have done something to show that interest, Mr. Davis said. It is the duty of the employer to place each employe where his abilities and interests will work out best for his welfare.

Mr. Davis urged hospital administrators and personnel directors to realize that when they are hiring they are acting as purchasing agents and should put as much stress on the quality of the employe whose services are being purchased as on any other large purchase. Having decided to try to employ a particular individual, the hospital officer then becomes a salesman who must persuade the applicant that the hospital has a good character and would be a satisfactory place to work.

Two Kinds of Leadership

A high point of the institute was the address by F. Alexander Magoun, professor of humanics at the Massachusetts Institute of Technology. Mr. Magoun, discussing the problem of supervising employes, pointed out that leadership could be of the commanding type or of the understanding type.

Almost every executive thinks he knows how to handle people, Mr. Magoun said, because he is in a position to command them. If we took away this power from executives, parents and teachers, many of them would soon learn how little they know about supervision.

At least 80 per cent of behavior is subconsciously motivated, he declared. There are two reasons for almost everything we do, the reason we give and the real reason. The psychosomatic relations of the individual were strongly stressed by Mr. Magoun. The conflict in each individual between conscience and desire, which should be, but often is not, controlled by wisdom, forms the basis for many difficulties.

A good supervisor attempts to find the real reason for human behavior and to influence that. The question then becomes not "What shall I do to him?" but "What do I need to find out about him?" Man has not conquered nature but has learned to cooperate with the laws of nature; we should do the same with the laws of human nature, Mr. Magoun stated.

Requirements for Cooperation

The speaker listed the following as the psychological requirements for cooperation: (1) the people involved are on a self-respecting status which involves self-government, reliable outlets for aptitudes, no subordination and sound judgment regarding values; (2) there is a continuing and healthy understanding of how the desires of each group affect the desires and performance of other groups; (3) there is confidence in the availability and effectiveness of good methods in solving human problems, which requires that both parties and particularly the one in power must search diligently for the truth, no matter how disagreeable, and (4) there is mutual responsibility for results.

In applying modern principles of learning to jobs and men, Clyde Hill, professor of education of Yale, states that psychologists have apparently proved that learning proceeds most rapidly when (1) the learner sees the relation of his education to his own welfare; (2) the learning is an outgrowth or development of the experiences of the learner; (3) the learning is satisfactory to the learner, and (4) the learning involves activity.

"The reward for learning must be inherent in the learning process itself," Mr. Hill stated.

Five steps in organizing a training program for employes were outlined by Ellis C. Maxcy, assistant to the vice president, Southern New England Telephone Company. They are: (1) define precisely whom you wish to train for what; (2) prepare appropriate teaching materials derived from job analyses and include pictures, charts, tours, demonstrations and other educational items; (3) conduct the actual teaching as informally as possible so as to develop in full the interest of the student since learning does not take place effectively without interest; (4) follow up the training to be sure as high a percentage as possible sticks, and (5) evaluate the results of the program.

Most training will be done by supervisors, Mr. Maxcy stated, so it is important to impress them with the significance of their training activities. He urged the use of Training Within Industry principles in teaching wherever applicable.

Some ideas that have much application to hospitals were presented by John W. Riegel, director of the bureau of industrial relations, University of Michigan, in discussing wage determination policies. He urged hospitals to relate their wage levels to the market rates by making surveys from time to time in their own communities to determine what rates are paid for jobs that are common to other industries. Then the uncommon jobs can be rated to bear the proper ratio to these "common" jobs. He strongly urged that wages and salaries be adjusted as far as possible by rational methods and not by waiting until pressure comes from employes.

Every employer should set up as a conscious goal that each employe should have a constructive work experience, so that he is a better man because he has worked for that employer. That was the challenge Eleanor H. Little, formerly of the personnel department of U. S. Rubber Company, threw to the institute personnel in discussing turnover. The employe's personality should flower and develop and not be stunted or misshaped by his work experience.

In dealing with the ticklish problem of labor unions, several speakers pointed out how they had learned to get along satisfactorily with unions. Gladys H. McCafferty, director of personnel relations of Harvard University, said it is easier for her to get along with A. F. of L. unions than it is with the Harvard Employes' Association, an independent union.

Leo Wolman, professor of labor problems of Columbia University, traced the growth of labor unions in the United States from a membership in 1914 of 2,700,000 to a paid-up membership in 1943 of 11,300,000. Even in the latter year, the unions embraced only about one fifth of the nonagricultural wage earners and lower salaried workers, he said. While approximately 85 per cent of miners and 70 per cent of construction workers are organized, only 33 per cent of factory employes, 10 per cent of government employes and 8 per cent of trade and service employes are members of unions.

Labor unions will lose members rapidly after the war, Mr. Wolman predicted, because much of the recent increase came in war industries but they will continue to be stronger than they were in 1933. He urged a modification of government policy so that unions would grow strictly on their merits and suggested that hospitals learn the art of dealing with unions.

There was general agreement among those attending the institute that hospitals of 150 or more beds should have personnel officers. The first prerequisite is to win the interest and support of the trustees, said James W. Stephan, director of Aultman Hospital, Canton, Ohio.

Personnel Department Takes Over

Then the personnel department can gradually assume such functions as employing; introducing workers to their jobs; maintaining personnel records; developing promotion, transfer, discharge and separation policies; initiating training programs, employe suggestion systems, remuneration and incentive plans and health and sanitation programs; eliminating fatigue and monotony; promoting safety; providing financial aids to employes, and developing employer-employe cooperation.

Mr. Stephan urged that personnel directors make haste slowly and sell themselves and their services to the various department heads so that there will be a minimum of friction.

The importance of raising hospital salaries and perquisites to a level that is competitive to the general level in the community was stressed over and over again by speakers and in discussion groups.

A Radiologist Replies

to Superintendent Brough's arguments in behalf of hospital v. *radiologist*

ALBERT OPPENHEIMER, M.D.

Roentgenologist, Margaret Pillsbury General Hospital and New Hampshire Memorial Hospital, Concord, N. H., and Laconia Hospital, Laconia, N. H.

IN THE article, "Objections Overruled," which appeared in the May issue of The Modern Hospital, Robert N. Brough stated that "from the standpoint of logic, common sense and the welfare of the public" charitable hospitals should be permitted to engage in the practice of radiology by means of employing a radiologist who is paid a salary for his services.

The conflicting views on this subject need not be recalled here; they have been repeatedly announced by the American College of Radiology, on the one hand, and the hospital representatives, on the other.

Instead of adding to the controversy by taking exception to Mr. Brough's argument, I would rather draw attention to some rarely publicized but significant points, hoping that this may contribute toward an equitable solution.

They Have the Same Goal

It should be kept in mind that radiologists and hospital administrators both want the same thing, namely adequate, competent and ethical x-ray service in and for the hospitals. Opinions differ as regards the methods by which this can be achieved.

Hospitals cannot attract competent radiologists unless conditions of work and financial arrangements are as satisfactory as those existing in radiologic practice outside the hospital. We are concerned here with only the financial aspects of the matter.

If hospitals cannot offer a remuneration commensurate with the ability, initiative and success of the radiologist, the radiologist will be led to maintain a private office in order to earn a fair living. The smaller the income offered him by the hospital, the more time will he have to devote to his private practice; and eventually his hospital duties will impress him as a necessary but burdensome and unprofitable service to the community. This is an unsatisfactory state of affairs.

Consistently good radiologic service in hospitals can no longer be had at bargain prices but most hospital administrators know that a well-paid and satisfied radiologist is a better financial asset than a poorly paid and dissatisfied radiologist.

There are essentially two types of radiologic services. First, there are the teaching hospitals in which all the heads of departments receive nothing but a salary, but the contract is nearly always on a permanent basis and includes retirement allowances, widow's pension, educational policies and similar features that free the radiologist from the necessity of creating an estate. He is in a position to accept a relatively low remuneration because this remuneration is permanent and he does not have to make provision for old age and disability.

Second, there are the much more numerous hospitals in which members of the staff are practitioners and specialists who maintain private offices and devote some of their time to the hospital. That these hospitals also have interns, residents and pathologists who are paid nothing but a salary is not relevant.

Surely Mr. Brough, when he mentioned these salaried positions as examples, did not mean to imply that the function of residents and interns can be compared with that of the chief of the x-ray service. If hospitals seriously placed a fully trained specialist on the same economic level as an intern, it would be useless to discuss the problem any further. Nor is the position of the pathologist, who has hardly any direct contacts with patients, comparable with that of the radiologist, whose success depends in a large measure upon his ability to deal with sick people.

The real point at issue is that the radiologist is a medical practitioner and no understanding can be reached if this is not appreciated. Like any other practicing medical specialist, he depends for his economic existence upon the confidence given him by his colleagues and by the patients. Hence, it takes several years until his professional standing in the community becomes established.

Looks First for Permanency

Unlike the pathologist, the radiologist cannot change his residence without having to reestablish his position at considerable cost in time and income. Consequently, when a mature radiologist considers a hospital appointment with a view to making it his main source of income, he is obliged to look first for permanency, or at least a long-range contract, and next for a financial arrangement that guarantees him a decent standard of living, commensurate with his efforts and similar to the standards achieved by other medical specialists in the community.

Experience has shown that this permanency cannot be obtained in all hospitals. Many institutions have offered radiologists a salary representing only a fraction of the income that competent specialists derive from private practice; retirement and other allowances are hardly ever granted, and the contract can be terminated at any moment, leaving the radiologist faced with the difficulties already mentioned.

A salaried position that has only the disadvantages and none of the advantages offered by the contracts with teaching institutions is inade-

quate to the needs of a radiologist. Permanency and an adequate income have not always been achieved where a so-called percentage agreement has been made because radiologists have repeatedly been placed, after several years of service, before the alternative of accepting a reduced share of the income or of losing their positions.

There are advantages for both parties in having the radiologist serve the hospital on a full-time basis, but hospital executives are too often inclined to consider "full-time" synonymous with "straight salary" or some other form of income control. Why should the radiologist alone be socialized while other specialists on the staff are allowed to write their own bills—both using the facilities that the hospital affords in essentially the same manner?

According to the declared policy of the American College of Radiology, hospitals are to receive from the radiologist an income large enough to defray all expenses incurred in operating the x-ray service, plus a liberal amount to pay the interest on the investment made. No other group of medical specialists has conceded to the hospitals so much.

The reason for the attempt at controlling the income of the radiologist, then, is the desire of hospitals to derive a profit exceeding costs and interest from the x-ray department. I do not know whether, from the legal point of view (which is the basis of Mr. Brough's argument), such a policy represents the type of medical practice that should be permitted to charitable hospitals.

At any rate, the x-ray department would then be operated by the hospital corporation on a profit-making, or commercial, basis, which, as Mr. Brough pointed out, is unlawful.

No matter what the legal interpretation, however, an equitable agreement can never be reached by stressing legalistic points, least of all in medicine. Unless we try to appreciate each other's needs, we cannot enter a constructive discussion.

Mr. Brough has ably reported the needs of the hospitals and the views of the hospital executive. In the interest of the understanding upon which a solution will have to be based, readers of this journal should also know the views of a radiologist, incidentally, of one who has worked in good harmony with many hospital administrations for more than twenty years.

I believe with Mr. Brough that logic, common sense and the interest of the public should dictate our attitude, but singling out a medical specialist in order to gain control of his income is not necessarily an action dictated by logic and common sense alone. Moreover, forcing competent radiologists out of hospital work into private practice by setting an arbitrary limit to their hospital earnings is hardly in the interest of the public.

Among the possible ways of solving the problem, the way indicated by Mr. Brough in his article leads, I fear, nowhere because it cannot be accepted by one of the two parties involved, and agreements are worthless unless they are mutually satisfactory.

An Intern's Credo

R. EMERSON SYLVESTER, M.D.
Assistant Resident, Newton Hospital, Newton Lower Falls, Mass.

I SHALL:

UPHOLD the dignity of my profession and remember the old adage that "undue familiarity breeds contempt."

REMEMBER my duty as a public servant and respond willingly.

REMEMBER that people less familiar with human nature, physiology and anatomy often get excited over little things, and that by being understanding and by giving proper information I can set many minds at ease.

REMEMBER that my approach to a patient, my voice and my expression are under close scrutiny at all times.

APPEAR most interested in every case and never appear tired or indifferent.

REFRAIN from transmitting my thoughts by untoward expression, and I shall not give an opinion without first understanding fully the case at hand.

REMEMBER that a great deal depends upon my judgment and it should not be given without reviewing in my mind and, when indicated, discussing with others all possibilities involved.

MAKE an effort to be most thoughtful and explicit with the patient's family.

REMEMBER that my judgment and opinions reflect on the standard of the hospital's care. Both suffer through errors.

REFRAIN from rushing one case in an effort to get to another.

REALIZE the limits of my abilities and responsibility and remain within them.

LEARN to develop and use my various sensory mechanisms and to report only those signs and symptoms I have found on actual examination and through scientific aids.

REFRAIN from openly expressing any criticism of any professional co-worker.

REMEMBER that a mere "I thank you" is the least I can say in appreciation to all who help me.

KEEP my records up to date.

This Medical Library "Gets Around"

ALBERT E. CASEY, M.D.
Pathologist, Baptist and Jefferson Hospitals, Birmingham, Ala.

ELEANOR H. HIDDEN, R.R.L.
Librarian, North Alabama Hospitals Library

STUDIES have shown that interns are reluctant to go back to the small cities and towns for the practice of medicine; this is even more pronounced in the case of young specialists. State medical schools have been organized with the hope of keeping native students in the state and encouraging them to locate in the small communities.

This will not solve the problem unless facilities comparable to those found in the larger cities are established in the smaller communities. Such facilities consist principally of adequate laboratory and specialty diagnostic services in the community hospital, consultation service by hospital administrators from the larger communities and, perhaps most important of all, really adequate library facilities.

Good Facilities for Small Towns

Facilities comparable to those found in the largest and best libraries in metropolitan centers can, we believe, be made available to the small community by proper cooperation between the community and metropolitan hospitals. The first need, of course, is an adequate library program and the second, the appointment of a research librarian capable of assisting the physicians in making full use of the library facilities and giving technical advice in the preparation of material for publication.

Moreover, a cooperative service for photography and illustrations and a cooperative medical museum of gross specimens, slides and photographs are essential.

Another important factor, which does not concern us here, is the use of graduate instructors for the teaching of various preclinical and clinical subjects in the schools of nursing.

In an analysis of the medical library facilities of Birmingham, it was found that at the present time the county medical library, which is housed in the Birmingham public library building, is not used to the fullest extent. This library, although fairly well stocked, is too inconveniently located to be of practical value.

Most physicians depend for their reading at the present time upon personally bought periodicals that are received in their offices. They supplement this with the material available in the hospitals with which they are associated. Requests for the preparation of manuscript material or educational data usually go through the hospital librarian.

In a recent publication of the American Library Association, it was stated that "the day when a personal library was adequate for a doctor's needs is definitely gone." It may also be said that the library in the average hospital is not adequate. Therefore, it behooves the hospitals to cooperate in such a way that a large medical collection, as well as the services of a research librarian, is made available to the group. Facilities could thus be provided that none could afford individually.

Such a plan has been put into operation in Birmingham. It is our purpose to describe the development of the hospital library on a cooperative inter-hospital basis whereby periodical, manuscript, art and illustration services and research library services are brought to the busy physician in the hospital in which he works; also the way in which these facilities are made available to a number of small hospitals in remote areas of the state.

The staff members of three hospitals in Birmingham and two in the near-by section met and agreed that each hospital would participate in the plan according to bed capacity and number of patient admissions. A librarian was appointed to coordinate the activities of the libraries of the various hospitals.

Inventories of the existing library in each hospital were made and combined at the central office, which is located in one of the larger hospitals in Birmingham. Then, with the aid of the library committee of each hospital, the librarian decided upon the additional journals and books to be ordered by each hospital. These publications were divided into two groups—a basic group (noncirculating) and a group to be circulated.

The basic group for each hospital consists of the *Quarterly Cumulative Index Medicus;* the *Journal of the American Medical Association;* a few of the more widely read journals in surgery and medicine, such as *Surgery, Gynecology and Obstetrics,* and some of the fundamental reference books of late edition on surgery, medicine and some of the specialties.

Build Up Back Volumes

These books are shelved in the hospital that purchased them. It was left up to the individual hospitals to obtain whatever books and journals they could by donation. Many of the back volumes were thus built up. A few books of cultural interest were also purchased and, gradually, a few collector's items are being acquired.

With the aid of the hospital medical library suggestions published by the American College of Surgeons, the A.M.A. Council on Medical Education and Hospitals and other sources, a list was made of the journals which are generally less read

than those mentioned, but which, on the whole, are attractive to the medical graduate.

In addition to the purely clinical journals, those technical and research journals were ordered that would make possible the operation of an up-to-date diagnostic service and the promotion of medical research and the technical training of physicians and technicians in laboratory science. These journals were divided among the hospitals, with a view toward having a well-rounded selection in each hospital, but at the same time avoiding duplication.

Thus, if one hospital subscribed to *Surgery,* another would get *Annals of Surgery* and another, the *American Journal of Surgery.* If a particular periodical was in great demand at a certain hospital, it was listed in the basic group, not to be circulated.

Unbound Journals Circulated

The current unbound journals are circulated among the hospitals, and an inter-library loan of books and bound volumes has been established. For example, when the February issue of a certain journal is received at one hospital, the January issue is placed on the reading rack of another hospital. A system has been worked out whereby within five months the monthly periodicals will have been circulated through all five hospitals. The few that are published less frequently will be somewhat delayed in circulating. Eventually, when the journals are bound, they are shelved in the hospital that originally purchased them and are then available for inter-library loan.

A master file is kept in the central office. The librarian spends half time at each of the two larger hospitals in Birmingham. At least a monthly visit is made to the out-of-town hospitals and to the smaller participating hospital in the city.

The circulating journals are brought to the hospital being visited and those that are to be put on the rack at another hospital are collected. Orders are checked with the person responsible for the library in the hospital being visited. Suggestions are made and, if there is time, the librarian instructs this person in ways in which she can aid the physician in making full use of the facilities of the library.

When books or bound journals are requested by telephone or mail, they are delivered in the most expedient manner to the person responsible for the books in that hospital. It is the responsibility of the individual in charge of the library at each hospital to see that the books are properly returned, inasmuch as she is directly involved in the transfer of the publication to the local physician.

At present, 84 different medical periodicals are being received, the more popular ones being duplicated. When world conditions permit, foreign journals will be obtained.

In order to stimulate interest in the library, the librarian attended the monthly staff meetings of each hospital, acquainted the physicians with the services offered by the modern librarian and reminded them of the facilities available from other medical libraries, such as the library of the American College of Surgeons, the Army medical library, the library of the American Medical Association and the Bacon library.

Staff members were encouraged to use the library in preparing cases for presentation at the staff meetings and weekly conferences. Those interested in organizing material for publication were urged to make use of the research librarian and the help that she could give. It was pointed out that material would be located and supplied to the physician in as convenient form as possible.

Assist Interns and Residents

Assistance was offered to interns and residents in making bibliographies. It was explained that the librarian had access to the county library and would be glad to obtain material and transport it to the hospital library so that it would be convenient for them. The doctors were informed that the librarian had visited libraries in hospitals that were not included in the set-up and that they had expressed their willingness to cooperate if they had some material that was not available elsewhere in the city.

It was explained that as the library grew and the staff increased, more service would be provided, and it was hoped that the degree of service given in a library of a large medical center would be approached.

As in any scheme, there are some disadvantages, which are, however, more than outweighed by the advantages.

There is greater chance of loss of current journals. However, if the rule (which is practically universal among libraries) is strictly observed that current journals cannot be checked out from the hospital reading room, there should be little or no loss, for eventually the unbound journals will be returned to the hospital that purchased them. Someone in each hospital must assume the responsibility for the library (usually the records librarian) and particular care must be taken of journals that have been purchased by another hospital.

All current unbound issues of a particular journal are not in one library. However, if there is a call for a particular issue, the librarian can obtain it without difficulty.

Some journals are a few months late in circulating to a hospital. This is, of course, better than not getting them at all.

Physicians Can Keep Up

By bringing the library to the physician and making it convenient for him to use, it is felt that the reading of current medical literature will be stimulated so that busy practitioners can more easily keep up with the rapid advances that are being made.

By supplying a research librarian, it is believed that much suitable and valuable material heretofore buried will be put to use. By pooling the resources of the participating hospitals, a more nearly complete library will be established.

It will thus more completely satisfy the demands of the research worker and the specialist; moreover, it will be adequate for the teaching of nurses, medical technicians, interns and residents. As additional help is employed, more service will be rendered and, perhaps, a master file can be kept at each division.

Our plan has been in operation for a short while only, but thus far there have been many more requests for magazines from our research librarian than were made in the same hospitals prior to the organization of the cooperative library. Furthermore, it has been possible to supply not only physicians in the city but those practicing in remote communities with special bound volumes and books through inter-library loan which would not have been possible under any other circumstances.

A Bulletin Does Its Bit

MOLLIE D. LURIE
Supervisor of Volunteers
Michael Reese Hospital
Chicago

The gift shop is managed completely by volunteers.

IT IS well over a year now since we published our first *Volunteers' Bulletin* at Michael Reese Hospital, Chicago. Looking back, I am both surprised and delighted with the results of this simple but effective manner of reaching the entire volunteer group.

Almost from the first day that I assumed the duties of volunteer supervisor, I was aware of the fact that it was easy to make individual but not group contact with our volunteers. When they came in as new workers, we asked them to attend an orientation course at which time we tried to interpret to them the rules and regulations governing their work.

After they had actually begun to work, I was able to reach them by making daily rounds and by holding individual conferences with them. But I had no way of reaching such a large group as a whole. I felt that a constant reminder of our rules would help keep them from growing lax.

For instance, there might be an epidemic of tardiness or of smoking in forbidden areas. Or some might have a spell of forgetting or misplacing their uniforms, while others would slip up in notifying me when they intended to be absent. In general, there were dozens of small ways in which they now and then became careless. For years this had also been a sore spot with my predecessors on the job.

I had posted notices, but to no avail. Few volunteers took the time to read them. I called a general meeting, but this was poorly attended. I had a committee of 10 volunteers who met with me once a month to air mutual problems, but their attempts to keep in touch with their fellow workers was necessarily limited, too. By what means then was I to reach the entire group?

Lunch trays are distributed and collected by volunteers, thus saving nurses many an extra step.

A chance conversation with a member of our woman's board gave me the answer. Several years back she had edited a small magazine called "The Voice of the Clinic." It carried educational articles about the hospital as well as social items. But it had become cumbersome and expensive to publish so it had been discontinued.

Out of this discussion was born our present bulletin. Then and there we decided to issue a monthly paper that could be inexpensively mimeographed in our printing department. In it we could suggest, correct or praise as the occasion demanded. It would be strictly business with no social items that might detract from its primary purpose.

With the approval of the administration I went "full steam ahead." First I called on a few members of the Committee of Ten to assist me since I felt that a bulletin for the volunteers should be by the volunteers. Naturally, at the beginning, the suggestions for material would have to come from me, but I hoped gradually to educate volunteers to bring in their own suggestions for the bulletin.

When the first edition came out, it was met with enthusiasm by every-

A volunteer worker "weighs in" two youthful clinic patients.

one. We had printed it on colored paper and intended to vary the color from month to month. We felt that it was more effective that way. Later, however, the shortage of paper interfered, and we had to go back to black and white.

Only enough copies were made at first to distribute to the clinic volunteers. I hadn't expected any particular interest from any other quarters. But to my great surprise, I kept getting requests for copies from many outside sources, such as personnel and woman's board members. So from then on we ran off enough copies to cover any requests that might come in.

As the months rolled by, we decided to have only one member of the Committee of Ten as my coworker. It was simpler to handle it that way. I began to collect my material from numerous sources. If complaints of a general nature came to me, I jotted them down. As praise for work well done or suggestions for improving methods were brought to my attention, I also made notes of them. Gradually I found that by the time I was ready to write the bulletin I had more than enough subject matter.

One month as I did my statistical report, it struck me that there were a great many women who were giving perfect attendance week in and week out. Why not recognize their faithfulness by publishing their names in the next bulletin? The idea was an instant success. The psychology of seeing their names in print worked wonders. Everyone whose name was not listed clamored to know why her name had been omitted. Each strove to make the list the following month. To add even more interest, we proceeded to star all names of women with two consecutive months of perfect attendance. This, too, met with popular response from the volunteers.

I realized now that publishing names had a definite value. So, gradually, I incorporated items with the names of all new workers who had come in during the month, as well as those women who had earned service pins. By this time even the husbands were aware of the bulletin. I kept getting reports from the women that their husbands were urging them to get on the perfect attendance list.

One day during the summer when many volunteers were away on vacations, I found myself short of help in several departments. A "help wanted" ad in the bulletin did the trick. As soon as the issue came out, I had many offers to fill the jobs. It was most gratifying.

When the war emergency necessitated expansion of our volunteer service to cover the entire hospital, we used the bulletin to advertise for more workers and included all these new ones among our readers. Later we began to publish their perfect attendance lists as well.

Several directors of volunteers in other Chicago hospitals heard about the bulletin and were delighted with the idea. Now they, too, are publishing little papers for their workers and finding it a useful means of communication. Our own readers' list grows from month to month.

I think the secret of the bulletin's effectiveness lies in the fact that we try to make it chatty and informal in style and that we limit its subject matter to business exclusively. The only social items we have ever mentioned pertained to the two teas for volunteers given during the year by the woman's board. Outside of that we have included only praise, corrections or suggestions, always with a view to treating the volunteers on a strictly professional basis. And as a result of constant campaigning, they are now coming to me with suggestions as are many of the employes who work with them.

Undoubtedly, our bulletin has been of inestimable value in tying together the loose ends of our volunteer service. In an institution as large as Michael Reese Hospital, we have to insist on a uniform set of rules for all our volunteers. Without it we would have constant confusion and misunderstanding. I can think of no better way of making the workers aware of these rules than by means of the bulletin. Nor can I think of any better method of giving recognition where recognition is due. A little appreciation goes a long way with volunteers.

What About Compensation?

for the injured volunteer or the person injured by the volunteer

W. F. SOMERVILLE
Secretary, St. Paul Mercury Indemnity Company

ON A recent checkup in the Congressional Digest to see if there had been any action taken on the bills pending before Congress for workmen's compensation for volunteer civilian workers, it was found that several bills are still pending on which no action has been taken.

No cases were found involving the liability of a hospital for injury to a nurse's aide or other volunteer hospital worker, or involving liability to a third party for a negligent act or omission of a volunteer hospital worker.

No Judicial Decisions

There have been no judicial decisions in the United States on this question. The attorney generals of several states have handed down advisory opinions regarding coverage of civilian defense workers under the workmen's compensation policies of various municipalities. In general, a mere volunteer, who does not receive remuneration and has no expectation thereof, is not protected under the Workmen's Compensation Act.[1]

The attorney generals of Ohio and Minnesota have held, on advisory opinions, that civilian defense auxiliary police or firemen are entitled to the benefits of the workmen's compensation acts of those respective states.[2]

Perhaps the auxiliary firemen, however, would have a favored status because of their similarity to volunteer firemen in those jurisdictions whose compensation acts either expressly, or by implication, include volunteer firemen; however, the opinions have some value on the problem of hospital liability to volunteer workers in that the objection that there is no remuneration is present in the case of volunteer firemen and yet workmen's compensation is allowed.

In considering the liability on the part of the hospital, it should be noted that there is a possibility of legal liability on the part of some of the other agencies responsible for recruiting civilian defense volunteers. The civilian defense committee of the American Bar Association in considering the legal status of a member of the Citizens Defense Corps discussed the problems from the standpoint of probable legal liability on the part of the state or municipality setting up the local defense council. (See "Civilian Defense Manual," O.C.D. Publication No. 2701, page 67.)

Some local defense councils have incorporated and could be sued directly. Also, the President of the United States has set up a special fund for the compensation of such workers, pending the passage of workmen's compensation legislation now before Congress. While such information is not directly material to the question of liability on the part of the hospital, it is of value in that it indicates that the hospital that uses the services of such volunteers is not in the field alone when it comes to legal liability.

In regard to the liability of the hospitals to the volunteer hospital workers, there is a good possibility that the hospitals would be held to be protected under the employer's liability coverage of the standard workmen's compensation and employer's liability policy.

The lack of remuneration that blocks the volunteer worker's recovery of workmen's compensation does not stand in the way of his recovery on the basis of a common law master-servant relationship. The general rule is that the relation of master and servant is created by contract, expressed or implied.

Master-Servant Relationship

Usually the critical element in such a relationship is not the payment of wages but the right to control and direct the activities of the servant. Volume 1 of LaBatt's "Master and Servant," Sec. 19, Chap. 2, reads as follows:

"One person may stand in the relation of master to another, although the former does not compensate the latter for his services.

"In Weisser *v.* So. P. R. Co. (1906), 83 Pac. 439; 148 Calif. 426, it was held that a student brakeman who received no remuneration was an employe of the railroad. The court said: 'The simple fact that he was not to be paid any money for his services cannot affect the question. . . . The important thing is that he voluntarily entered and was engaged in the service of the defendant on

[1]Matter of Farrington, 228 N. Y. 564 (1920), opinion of the attorney general of California to the executive director of the State Council of Defense, Jan. 7, 1942. No. NN3973. Opinion of the attorney general of Illinois to the Illinois State Council of Defense, dated April 1, 1942.

[2]See Ohio attorney general's opinion No. 5428, Sept. 5, 1942; Minnesota attorney general's opinion-Marshall B. Thornton, Jan. 16, 1942.

such terms as he had seen fit to agree to.'

"In Huntzicker *v.* Illinois Central Ry. Co. (1904), 64 C.C.A. 75; 129 Fed. 548, the court held similarly in a case involving a student flagman. See also Reed *v.* Dry Dock Ambulance, Inc. (1925), 212 Ala. 428; 102 So. 906, in which the plaintiff was a partially disabled soldier who had become a vocational student under the War Risk Insurance Act of the federal Congress. The court said: 'The essentials of the relationship of the employer and employe are voluntary rendition of services, its acceptance by the employer and the employer's right to direct and control the employe; the payment of compensation is merely incidental.'"

Situation Is More Advantageous

If the volunteer sues on the theory that he is an employe and that the relation of master and servant exists between himself and the hospital, the situation differs and in some respects is more advantageous than if the volunteer is regarded as having the legal status of a mere business invitee (one whose presence on the premises is of economic benefit to the owner).

The majority of American hospitals are charitable or nonprofit institutions and as such claim immunity from tort liability. The weight of authority is that this immunity does not extend to the employes of such hospitals.[3]

A small minority group holds that a charitable hospital is not liable for injury to an employe.[4]

In Kentucky, Massachusetts and Missouri the volunteer worker has no case at all against a charitable institution; his action as an employe is barred by judicial decision, and as an invitee it is barred by special statute.

In some states it is immaterial whether the injured volunteer is an employe of the hospital or is a business invitee because these jurisdictions have held that charitable institutions are not immune from suit by business invitees. In these states, the volunteer would probably proceed as an invitee because after getting into court his case is somewhat easier to maintain.

Alabama, California, Connecticut, Florida, Georgia, Idaho, Illinois, Iowa, Louisiana, Michigan, Minnesota, Mississippi, Nebraska, New Hampshire, New Jersey, North Carolina, North Dakota, New York, Ohio, Oklahoma, Tennessee, Texas and Virginia have ruled that a stranger, third person or invitee can recover from a charitable institution. Whether an employe or invitee, the hospital's duty to the injured volunteer would be substantially the same, *i.e.* to use reasonable care to put the premises in a safe condition; however, as against the invitee, the hospital would not have available the defense of negligence on the part of a fellow servant.

The question of whether an invitee can sue a charitable hospital has not yet been decided in Arizona, Arkansas, Delaware, Indiana, Montana, Nevada, New Mexico, South Dakota, Utah, Vermont and Wyoming.

When the hospital is governmentally owned, the law of municipal corporations would apply and here the general rule is that if the operation of a hospital is classified as a proprietary activity, the hospital volunteer, whether considered as an employe or as a business invitee, can sue. Also, such a public hospital, operated in the proprietary capacity of the city, would be liable to third persons injured by the negligence of hospital volunteers.

Governmental Hospital Immune

On the other hand, if the operation of the hospital is classified as "governmental," it is immune from liability and cannot be sued. Four cases have held the operation of a hospital to be a proprietary activity.[5]

Seven cases hold that the operation of a hospital is a governmental activity, and, therefore, immune from suit.[6]

When the hospital is proprietary, operated for private gain, its liability to suit is greater than that of either the charitable or public hospital. It is here that the need for adequate insurance coverage is the greatest. Private hospitals, under the rules of the general law of negligence, are liable both to their employes and to strangers, third parties and business invitees. Also they are liable to patients injured through negligent acts or omissions of employes.

As stated in regard to charitable institutions, the possibilities are good that the volunteer worker would be held to be an employe and, as such, covered by the employer's liability coverage of the standard workman's compensation and employer's liability policy.

The insurer could contest the volunteer worker's claim as an employe because there is a shade of doubt regarding it. This is for the reason that, while the general rule is that lack of remuneration is not conclusive in negativing common law employer-employe relationship, the closest cases in support of this rule involve students or apprentices, who differ somewhat from civilian defense volunteer workers.

Policy Protects Hospital

The public hospital's liability to a civilian worker as a business invitee and its liability to patients for negligence on the part of such workers are governed by the general law of negligence and a comprehensive hospital liability policy would give protection to the hospital for claims of this nature.

In the majority of states the insurance companies may extend, at a small charge, their comprehensive liability policies to include the interest of any volunteer worker whenever such loss arises out of the care and treatment of patients of the hospital and may also extend the same policy to pay the reasonable cost of medical, surgical, hospital and ambulance service necessary for the treatment of an injured volunteer worker or student nurse, when injuries are sustained by her while engaged in the service of the hospital.

[3]14 A.L.R. 581, Bruce *v.* Central M.E. Church (1907) 147 Mich. 230; 110 N.W. 951. McInerny *v.* St. Luke's Hospital (1913) 122 Minn. 10, 141 N.W. 837. Hewett *v.* Woman's Hospital Aid Association (1906) 73 N.H. 556; 64 Atl. 190. Hondern *v.* Salvation Army (1910) 199 N.Y. 233; 92 N.E. 626. Arnendarez *v.* Hotel Dieu (1902) Texas, 145 S.W. 1038.

[4]Emery *v.* Jewish Hospital (1921) 193 Ky. 400; 236 S.W. 577. Farrigan *v.* Pevear (1906) 193 Mass. 147; 78 N.E. 855. Whittaker *v.* St. Luke's Hospital (1909) 137 Mo. App. 116; 117 S.W. 1189.

[5]Sanders *v.* City of Long Beach, 129 Pac. (2) 511. City of Miami *v.* Oates, 10 S. (2) 731. City of Brunswick *v.* Barrett, 199, S.E. 901. City of Okmulgee *v.* Carlton, 71 P. (2) 722. Okla.

[6]Smith *v.* City of Dallas, Tex., 163 S.W. (2) 681. Scott *v.* City of Indianapolis, 130 N.E., 658; 75 Ind. App. 387. Browder *v.* City of Henderson, 182 Ky. 771, 207 S.W. 479. Young *v.* City of Worcester, 253 Mass. 481; 149 N.E. 204. Zumno *v.* Kansas City, 285 Mo. 222, 225 S.W. 934. Bradley *v.* City of Jackson, 119 So. 811; 153 Miss. 136. Lloyd *v.* City of Toledo, 42 Ohio, App. 36, 180 N.E. 716.

"Straight Salary"

leads all the rest as compensation for radiologists

SMALL hospitals, like the larger ones, pursue a variety of methods of compensating radiologists. Of 50 inquiries sent out on this subject, 25 were returned. These were supposedly addressed to hospitals of 150 beds or less, but three of the reporting hospitals have increased their capacity beyond 150 beds.

The most popular method is by a straight salary paid for part-time service, 10 of the 25 hospitals reporting this method. In discussing this plan, the following advantages and disadvantages were mentioned by the hospitals:

"There is no other satisfactory method in a hospital designed primarily for indigent patients."

"It is inconvenient to have a radiologist on part time and we would prefer full time."

Bookkeeping Is Simplified

"This method simplifies bookkeeping and permits us to offer an inclusive rate service which is highly beneficial to patients and is not, we believe, abused by the physicians."

"There is less incentive to develop the department and a percentage of net income would be better."

"There is no artificial limitation on diagnostic studies or treatments by the medical staff."

"Work is more closely integrated with the college student health program and cost is reduced" (a small town college hospital).

"This plan controls the mercenary attitude of the radiologists, permits a better arrangement for free work and better diagnostic work."

"It simplifies bookkeeping but exploits the radiologist because the hospital makes money on the department."

"It is a simple plan and we like it."

The answer charging exploitation was prepared by the president of a hospital board whose last name is the same as that of the radiologist in the town. All but two of those hospitals reporting straight salaries wish to keep this plan.

Paying the radiologist a percentage of the net income of the department is the next most popular plan, with seven hospitals reporting it. Six of these hospitals report that the plan is satisfactory although one of them would like to change the percentage from 25 per cent of the first $200 of net income plus 50 per cent of the remainder to 50 per cent of the first $200 plus 33 1/3 per cent of the remainder.

The seventh hospital states that this plan has the advantage of paying according to the income of the department but has the disadvantage that "we must permit the doctor to take private ambulatory cases to his own office." This hospital would like to switch to a straight salary arrangement in the hope that it would make the department self-supporting.

Four hospitals pay the radiologist a percentage of the gross income. Two of these report the arrangement is satisfactory. One believes that the percentage is too high but is uncertain about making a change. The other says that the plan is not desirable but that it works satisfactorily in this instance because the radiologist is extremely cooperative. This hospital would like to shift to a percentage of net income basis.

Two hospitals report that they pay salaries plus a percentage of the gross income over $16,000 and over $22,000 annually. Both report that they are well pleased and do not contemplate any change, although one hospital mentions that the bookkeeping problem becomes a bit involved.

Only one hospital reports that the department has been leased to the radiologist. It adds that, while the plan removes worry from the hospital, it also removes any hospital control, endangers the cooperative principle and permits the possibility of indiscriminate charging of fees. This hospital would prefer to have a straight salary arrangement.

One small hospital pays a fee to the radiologist for each service and is satisfied with that arrangement.

The hospitals were asked: "Can you estimate the annual net income of your radiologist? How does this compare with incomes of other doctors in the community with similar background, experience and responsibility? So far as you know, is your radiologist satisfied with the present arrangement?"

The answers to the first and third of these questions are given in the accompanying table. As will be seen the amounts reported range from $1500 to $15,000. But 10 of the 19 hospitals that estimated this figure could give only part of the income since the radiologist also works for other hospitals or conducts a private practice.

Income Above Average

Of those who attempted a guess (and obviously such an answer could be little more than a guess in most cases) as to the comparative income of the radiologist, 10 estimate that the radiologist's income is higher than the average for other doctors in the community with similar background, experience and responsibility; three think it is about the same, and two believe that it is below the average.

Twenty-one of the reporting hospitals state that, as far as they know, the radiologist is satisfied. One superintendent of a state hospital whose radiologist also serves eight or nine other hospitals in the area and conducts a private practice writes:

"I am unusually fortunate in having an outstanding individual. He not only is an excellent radiologist but is extremely conscientious. He is carrying a tremendous load, driving himself at a terrific pace at all times. In fact, if anything were to

Incomes of Radiologists in 25 Small Hospitals

Hospital	*No. of Beds*	*Type of Payment*	*Annual Net Income*		*Is Radiologist Satisfied?*
1.	66	Fees			
2.	100	Salary	$2,400	plus income from 8 or 9 other hospitals and private practice	Yes
3.	100	Per cent of net	5,360		Yes
4.	105	Salary	10,000		Yes
5.	108	Per cent of gross	15,000	plus income from two other hospitals	Yes
6.	110	Per cent of gross	6,000	plus several other hospitals	Yes
7.	120	Salary	4,800	plus three other hospitals and private practice	No
8.	120	Lease	12,000		Yes
9.	124	Per cent of net	15,000		Yes
10.	125	Salary	1,500	plus outside practice	Yes
11.	125	Salary	7,200		No
12.	125	Per cent of net	3,000 - 3,600	for from 4 to 6 hours weekly	Yes
13.	125	Salary	.....	college salaries and living costs low	Yes
14.	125	Salary	14,000		Yes
15.	126	Salary	12,000		No
16.	135	Per cent of gross	7,000	plus large private practice	Yes
17.	145	Salary plus commission	15,000		Yes
18.	150	Salary	.....		Yes
19.	150	Salary plus per cent of net	.....	plus another hospital and private practice	Yes
20.	150	Per cent of gross	6,500	plus other income	Yes
21.	150	Guarantee plus per cent of gross	.....		Yes
22.	150	Salary	6,000		Yes
23.	162	Per cent of net	6,000	plus private practice	Yes
24.	184	Per cent of net	5,000	for from 7½ to 10 hours weekly	Yes
25.	250	Per cent of net	.....	part time	Yes

happen to him, the already low standard of medicine in this area would suffer a severe drop. The salary I am paying him, in relation to the volume of work, does not begin to compensate him for the actual amount of time, interest and work he puts in here.

"However, I know he is entirely satisfied and happy because of the unusual situation in this hospital where he is able to work with a full-time staff, namely, a pathologist, surgeon and radiotherapist. All of these men are well-trained, alert, progressive individuals and diplomates of their respective specialty boards.

"We have weekly clinical pathologic conferences and weekly staff meetings whereby all interesting cases are gone into from every angle. As you know, we are limited to indigent residents of this state."

Another superintendent whose radiologist appears to be happy with the present arrangement describes it as follows:

"We do not have a full-time radiologist and since there is no radiologist in town we have the following arrangement. Our radiologist comes to the hospital each Wednesday afternoon. All gastrointestinal work is scheduled for this day. He remains at the hospital until all patients are cared for and the films from the previous week are read. He spends from four to six hours at the hospital each week. If an emergency reading is required, the film is sent to him and he telephones the report to us.

"For this he receives from $3000 to $3600 a year as a percentage of net income. If he is able to do as well for the rest of the week, his total income would be above $25,000 per year."

Another superintendent reporting a "perfectly satisfied" radiologist points out that "the hospital has furnished the best and newest in x-ray equipment, for both radiology and therapy, and well-prepared technicians." He received $7000 in 1943 from the hospital and conducted a private practice of roentgenology and radium therapy.

Another administrator whose radiologist receives $15,000 net income says that other doctors "should make more than that but considering their expenses and uncollectible accounts, perhaps they do well to make $15,000."

One radiologist who receives $6000 as 40 per cent of the income of the department after paying for films and technician's salary is also given free office space and room for deep therapy equipment. "The hospital does not own the deep therapy equipment or maintain it at all," states the superintendent. "All revenue from deep therapy is handled by the radiologist himself without any contact with our business office. Our radiologist seems particularly well satisfied, having continued on this arrangement for a good number of years."

A New England administrator says that his radiologist receives $5000 per year for from seven and one half to ten hours of work per week. "His remuneration is higher than the average for other medical men, I am sure." Naturally, with such an arrangement, the administrator believes that the radiologist is satisfied.

Three hospitals state that their radiologist is not satisfied with the present arrangement. One of these is the hospital in which the president of the board states that the radiologist is exploited. In the second hospital the radiologist receives $4800 a year from that hospital on a straight salary and also works for three other hospitals and conducts a private practice. Although the administrator believes that his income is probably "on a par with that of our busiest surgeons," he would prefer a percentage system.

In the third hospital reporting dissatisfaction of the radiologist, the administrator states that this is "the hardest department to satisfy. The radiologist wants more help, is less willing to cooperate, is unwilling to share responsibility, does not desire to participate with the rest of the group and seems to feel that a few hours a day are all that are necessary." For these few hours a day he receives a straight salary of $7200 which, the administrator states, is

"above the average" for that community.

The replies to this inquiry were well scattered, no two coming from the same state or province.

Since the inquiry was sent out the report of the conference committee of the American Hospital Association and the American Medical Association on the relations of hospitals to radiologists, pathologists and anesthesiologists has been adopted by both organizations and published.

This report reaffirms the principles of relationship as approved in 1939. As regards radiologists these principles read as follows:

"1. The radiological service of the hospital shall be maintained primarily for the benefit of the sick.

"2. Every hospital radiological department should be under the direction of a competent radiologist, preferably a diplomate of the American Board of Radiology or one who is working toward that objective. If, because of size or isolation, such arrangement be not feasible, some member of the general medical staff trained in radiology should be in charge and a consultation service arranged with a near-by radiologist.

"3. The radiologist is entitled to recognition as a professional member of the medical staff and as head of a hospital department.

"4. The preservation of the unity of the hospital and its component departments and activities is an essential administrative principle. This principle can be maintained without any infringement on professional rights or professional dignity.

"5. Inasmuch as no one basis of financial arrangement between a hospital and its radiologist would seem to be applicable or suitable in all instances, that basis should be followed which would best meet the local situation. This may be on the basis of salary, commission or privilege rental, but *in no instance should either the hospital or the radiologist exploit the other or the patient* (italics added).

"6. When an arrangement is effected whereby the radiologist of the hospital pays a rental for space and service, cares for nonpay patients and in return retains all private fees collected, such contract should clearly cover the matter of depreciation of equipment, replacements and additions, should protect the radiologist against excessive nonpay work and should take into consideration the 'good will' by virtue of which a large proportion of the paying clientele is attracted."

It is evident from the 25 replies received to this inquiry that the small hospitals are finding bases of remunerating radiologists that "meet the local situation." Whether they are on salary, percentage of gross income or percentage of net income, the radiologists with few exceptions seem to be satisfied. They apparently have larger incomes than other physicians, which may be due in part to the fact that they obtain a monopoly of hospital radiologic work.

At the present time, of course, there is a serious dearth of radiologists as there is of most other medical specialists. Undoubtedly, many of the radiologists are overworking in an attempt to keep even with the increased demand for their services.

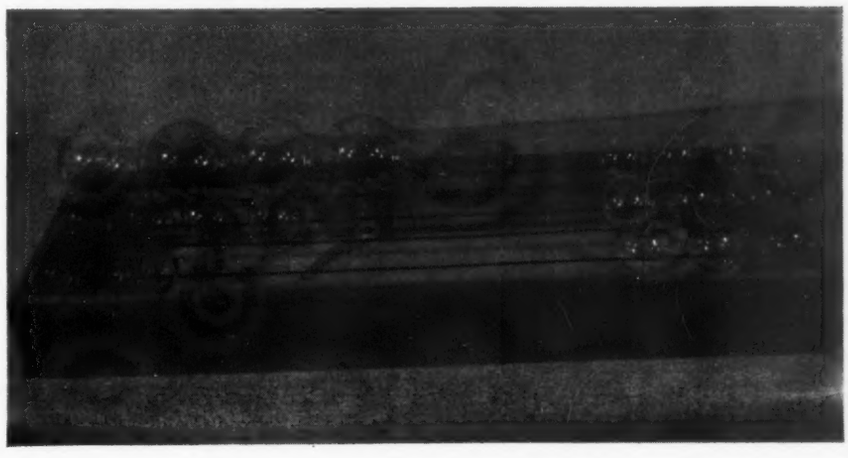
When the war is over there will be a change. In addition to the trained radiologists who went into the Army, a great many other physicians have received special training in radiology during their Army service. Doubtless, this training plus the experience obtained in the Army will be accepted as partial fulfillment of the three years of special training required by the American Board of Radiology for certification as a specialist. Thus the present dearth of radiologists may be followed by an oversupply within a few years. Radiologists should not exploit hospitals or patients now during the period of dearth nor should hospitals exploit radiologists in the future when the situation is reversed.

What constitutes "exploitation" on either side is, of course, open to argument. The A.H.A.-A.M.A. agreement does not attempt to define it. Certainly, a situation in which the radiologic fees exceed those of the physician or surgeon in direct charge of the patient would seem to indicate exploitation of the patient for the benefit of either the radiologist or the hospital.

Rack Reduces Breakage

IN CONNECTION with the operation of the central supply department of Highland - Alameda County Hospital, Oakland, Calif., there is a great deal of washing of solution bottles and much time is required for their drainage. The supervising nurse in charge of the department conferred with the superintendent of maintenance, who devised a rack so made as to hold the different sizes of bottles used in making solutions in a position that will make proper drainage possible.

The rack consists of a rectangular frame strung with wire, gauged and arranged to hold various sized flasks. Through use of this rack, breakage is reduced materially, and proper drainage is accomplished without the long delay otherwise necessary. Its use is a most important part in the handling of solution bottles.—BENJAMIN W. BLACK, M.D., *Highland-Alameda County Hospital, Oakland, Calif.*



Administrators

Robert S. Hudgens, superintendent of Emory University Hospital, Emory University, Ga., since 1937, resigned July 15 to become director of hospitals at the Medical College of Virginia, Richmond, succeeding **Dr. Lewis E. Jarrett.** Mr. Hudgens has been active in the state, regional and national hospital associations and is a member of the American College of Hospital Administrators. A graduate of Emory University, he has been associated with the hospital since 1929. His successor has not yet been named.

Capt. Earl C. H. Pearson has returned to his former post as superintendent of Good Samaritan Hospital, West Palm Beach, Fla., after twenty months of active duty with the Army Medical Administrative Corps. Captain Pearson has been placed on the inactive list of the Army and will retain this status as he resumes his duties at the hospital.

David M. Dorin, formerly assistant director of Beth Israel Hospital, New York City, has been chosen as executive director of Sydenham Hospital, New York City. Last December the hospital was reorganized on a fully interracial basis, with a board composed of six Negro and six white trustees. The interracial policy is also followed in the medical, nursing, administrative and other staffs. It is believed to be the first voluntary hospital to inaugurate the interracial idea.

Frances Chappell, former superintendent at North Country Memorial Hospital, Glen Cove, N. Y., has been named head of Memorial Hospital, Owosso, Mich.

Dr. David W. Park has resigned as superintendent of Potsdam Hospital, Potsdam, N. Y., to join the staff of the American College of Surgeons.

Dr. J. C. Stratton has been appointed administrator of Middletown Hospital, Middletown, Ohio, succeeding **Ada Leonard,** who resigned early in the year.

Mrs. Irene E. Oliver has resigned as superintendent of Weymouth Hospital, South Weymouth, Mass., after being associated with the institution for eighteen years.

Thomas P. Langdon has been named head of Hahnemann Hospital, San Francisco, succeeding **Paul Fleming.** Mr. Langdon was formerly a member of the hospital board of trustees and was secretary of the Park Commission of San Francisco.

James L. Dack, administrator of South Haven Hospital, South Haven, Mich., has been appointed administrator of Community Hospital, Battle Creek, Mich., succeeding **Mrs. Elizabeth Nichols. Francetta Peters,** director of nurses at South Haven Hospital, succeeds Mr. Dack as head of the institution.

Rev. W. C. Perdew, formerly pastor of the Methodist Church in Kalamazoo, Mich., has assumed the duties of administrator of Bronson Methodist Hospital in that city. The Rev. Mr. Perdew succeeds **Rev. Alfred F. Way,** who is now director of public relations and fund raising of the hospital.

H. Louie Wilson resigned on July 15 as manager of Floyd Hospital, Rome, Ga., to accept the post of business administrator of the Albany Medical Center, Albany, Ga., which includes the present Phoebe Putney Memorial Hospital. Mr. Wilson began his hospital career in 1926 as a clerk in the records department of Grady Hospital, Atlanta. In 1939 he became business manager of the Ware County Hospital, Waycross, Ga., and left there in June 1942 to accept a similar position with Floyd Hospital. Mr. Wilson is a trustee of the Georgia Hospital Association.

Sister Hermana of St. Mary's Hospital, Decatur, Ill., is the new Sister Superior of St. Nicholas Hospital, Sheboygan, Wis. She succeeds **Sister Canisia,** who has been transferred to St. John's Hospital, Springfield, Ill.

Sister Helen Clare has been named to succeed **Sister M. Adelaide** as Sister Superior of St. Joseph's Hospital, Parkersburg, W. Va. She was formerly operating room supervisor of St. Mary's Hospital, Clarksburg, W. Va.

Dr. W. W. Coulter Sr. on July 1 assumed the duties of administrator of Jefferson Davis Hospital, Houston, Tex. Prior to this appointment, Doctor Coulter was director of the pathological laboratories. He has been on the visiting staff of the hospital since 1920.

Elsie L. Delin, R.N., formerly administrator of McKinney City Hospital, McKinney, Tex., has accepted the appointment of administrator of Memorial Hospital, which was recently opened in Corpus Christi, Tex. **Sara Frazier, R.N.,** succeeds Miss Delin at McKinney.

Dr. Carl W. White is the new superintendent of Lynchburg State Colony at Colony, Va.

J. M. Wolden resigned recently as manager of Coleman Hospital, Estherville, Iowa, to become administrator of Fairmont Community Hospital, Fairmont, Minn.

Dr. C. G. Salisbury, medical director of Sage Memorial Hospital, Ganado, Ariz., was chosen as president-elect of the Association of Western Hospitals at the annual meeting held July 5 in San Francisco. Doctor Salisbury is currently serving as president of the Arizona Hospital Association. Other officers elected are: first vice president, **Gordon Gilbert,** St. Luke's Hospital, Spokane, Wash.; second vice president, **Dr. John C. Sharp,** Monterey County Hospital, Salinas, Calif., and treasurer, **George U. Wood,** Peralta Hospital, Oakland, Calif.

Julian G. Hart, president of the board of trustees of Victory Memorial Hospital, Waukegan, Ill., has assumed the position of administrator of the institution, following the resignation of **Victor S. Lindberg,** which was reported recently.

James P. Richardson on June 15 accepted the appointment of administrator at Presbyterian Hospital, Charlotte, N. C. He was formerly administrator of High Point Memorial Hospital, High Point, N. C. **W. R. Peters** succeeds Mr. Richardson at High Point.

Blanche Jackson, R.N., is the new administrator of Good Samaritan Hospital, Sterling, Colo.

Richard J. Stull has resigned his position as head of Phoenixville General Hospital, Phoenixville, Pa., to become administrator of Norfolk General Hos-

(*Continued on Page* 134)

We Can Keep Up Our Standards of nursing care and service

BARBARA A. THOMPSON, R.N.

Director of Nursing
St. Luke's Hospital
Denver

WHAT is nursing service? What is nursing care? The two terms are not synonymous. Nursing care might be defined as adapting prescribed therapy and preventive treatment to the specific physical and psychic needs of the individual. Good nursing care really requires in the nurse, in addition to these ideals, love, sympathy, knowledge and culture.

Nursing service may be all of these but really includes much more that is not nursing care. If most of the nursing service duties could be allocated to well-trained auxiliary workers what a heaven on earth the nurse would have!

If we could do this, would we need the thousands of trained nurses the country is asking for? Does the hospital need a trained nurse to make out drug, laboratory and the other various and sundry charges that are not routine on all patients? In many places nurses are still being used for admission clerks, for relaying telephone messages to relatives of patients and even as relief telephone operators.

Architects Should Do the Work

It has been my privilege to work in various types of hospitals and I have also had the opportunity of surveying many schools of nursing throughout the country. I have thought many times that I would like to see some of the hospital architects put on a nurse's uniform and take care of patients for just one day in some of the physical plants that they have been responsible for planning. One day would be about all any of them could stand in some situations. I venture to say that not one of them ever asked the question, "Now how many steps is the nurse going to have to take in the care of this patient?"

I have been in university hospitals planned by university architects and in wards of 60 beds the medicine cupboard, only large enough to hold a dozen good sized bottles, was located at a considerable distance from the patients. It is not uncommon to see utility rooms located half a block from the last patient. These are bad mistakes from the standpoint of efficiency in the care of patients and increased personnel becomes necessary—if such can be obtained in these times.

A study of how many times the nurse goes back and forth in long corridors will reveal ways and means that can be taken to ease the burden and every effort should be made, even at this time, to obtain equipment that can be used to cut down extra steps and thereby maintain standards with decreased personnel. Industry would certainly put on experts to see what could be done to apply human energy with maximum effectiveness.

Another great time-saver in hospitals is an intercommunication telephone system between departments. I have never had the pleasure of working in a hospital where there was one but I am sure that if the time that nurses take in trying to get other departments by way of a central switchboard could be measured the loss in man hours would be found to be sufficient to pay for the installation.

Reduction of time in the performance of nursing procedures should be constantly studied. We have nursing procedures in our books that have whiskers. For example, one gray-haired, conscientious nurse had for years been preparing periodically a cumulative index. The work used to involve 27 "steps" and take 600 hours. She has cut the steps to 12 and can now do the same job in 200 hours.

She was asked why she didn't think of that before. Her reply was "Because I wasn't supposed to think like that before. I was told how to do it, and there were rules higher up that forced me to take those unnecessary steps. When the breakdown showed how pointless they were, we got them changed."

"They've Always Done It"

I recall vividly one survey I made in which I found that the nurses were soaking medicine glasses and other equipment in an antiseptic solution and then dropping them into a sterilizer to boil. When asked why they used such a lengthy procedure, their only answer was "Oh! I don't know—I guess it's just because we have always done it that way."

In one hospital a committee of the faculty was appointed to study ways and means of effecting economies of nursing service. The skeletons that this committee unearthed looked, when brought out into the open, as though they belonged to the dinosaurian age.

From a paper presented at the American College of Surgeons war conference in Denver, 1944.

Getting into the habit of looking at methods and procedures in a critical manner is good brain exercise and although there may be people who will not like to have the even tenor of their ways disturbed, they are going to have to get into line if we are going to win this war. Studies, even though slowly made, will reduce labor turnover and loss of supplies and time and, without doubt, will maintain standards—perhaps even raise them. To aid in these studies, reference to the various professional magazines and also to pamphlets put out by commercial companies is recommended. They are full of worth-while ideas for short cuts.

Business Is Not as Usual

There was a time when "business as usual during alterations" was a matter of pride. The present chaotic state of the world does not permit that. When we go to the store, can we now say to the clerk "charge and send"? Well, to anyone who has not tried that, I would suggest that he do it and see what kind of answer he gets.

Have we helped the public to see that business in hospitals cannot go on as usual? The doctor, without any real inconvenience, could save hours of nursing time. He could remember hospital regulations and refrain from assuring the patient's relatives that they could come in any time. Visitors seriously interfere with the work of the nurse in the care of patients.

Doctors could also dispense with the attendance of a nurse on many of their routine visits. Many of the time-honored routines—again, because "we have always done it"—could be dropped. Patients who have had normal temperatures for some time could have the number of times the temperature is taken reduced. Records on charts for patients with conditions so unvaried that the nurse fills in only the space "comfortable day" could probably be discontinued. These are just samples of what might be done in this war period to conserve the nurse's time and energy.

What are we really doing, and doing with a great deal of effort, to alleviate personnel shortages and maintain standards of nursing service and nursing care? The national plan of increasing the number of students in schools of nursing through the establishment of the U. S. Cadet Nurse Corps is bringing good results. This year 65,000 students must enter schools of nursing in order to fulfill the demands of the military forces and also supply the civilian services.

The second plan toward filling the gaps in nursing service and nursing care of patients is the use of the volunteer worker. There was a time when many of us would have frowned on volunteer help. The success with which the Red Cross volunteers have fitted into the picture is certainly indicative of what can be done with a selected group of people who have been well taught and well supervised.

Tremendous efforts have been made to bring back into service all nurses who have been inactive. Refresher courses and other opportunities have been offered these people and the results have been most gratifying.

When the procurement and assignment committee swings into shape throughout the country, a more equitable distribution of nurses should be possible. Luxury nursing is still here. The public and also the doctors still need to be brought to the realization that the time has passed when patients should have three special nurses to entertain them when there are other patients who are suffering for lack of the minimum essential in nursing care. There are still too many, and I include nurses as well as others, who are still living under the misapprehension that we should have business as usual.

Another plan that is meeting with favor all over the country, not only in providing sufficient staffing but in bolstering morale, is to have office nurses, nurses in industry and private duty nurses give some time to the institution. Do not mistake me—not for nothing. In many sections of the country a plan has been worked out for rotating nursing service. So far no such plan has been put into effect here in Denver.

Another essential in maintaining standards today is for key nurses, those who are holding essential administrative and teaching positions, to remain at their posts in spite of the requirements of the armed forces. In order to retain these people and to make them as efficient as possible, we must not forget that good conditions of service must be maintained.

A nurse who has reasonable working hours, regular vacations, good living conditions and good food will be far better equipped to meet the present emergency than one who does not have all of these things. Ultimately, also, the effectiveness of this program will depend upon the individual nurses.

It is only if each and every nurse accepts her responsibility to find the place where she can best serve, lives up always to the ethics of her profession, performs her functions to the highest point of her ability and guards her own health as a patriotic duty that high standards of nursing service under war-time conditions can be achieved.

In the postwar period we are facing the crossroads not in nursing alone but in nursing care and service. We shall no longer live in an isolated country; airplane travel will see to that. We are going to have to learn to live with people of all races. Nurses have been too cloistered in the past because their tasks have been arduous and their time too occupied with trying to surmount the difficulties resulting from some of the factors that I have mentioned.

Keep Nursing a Profession

If I am not mistaken, the present generation of nurses who will fill the positions of us who will be retired will be more vocal in its demands than we have been. We want to keep nursing as a profession. Let us dignify it by satisfactory conditions of living, working and remuneration. If we look to these goals, there will never be any danger that someone else will step in and try to sponsor the nurses' cause. And last but not least, in future catastrophies we will not have to worry about whether we can maintain the standards of nursing service and nursing care.

Let us start planning the house we are going to have after the war just as industry is now developing new plans for houses after the war. As one writer said, "What we need more of in hospitals are vision, imagination and courage—through vision we see things as they really are, through imagination, we dream of things that may be and through courage, we act boldly to make things come true."

Church Hospitals Need "Something Extra"

REV. WILLIAM C. HARTINGER
Hospital Minister, Methodist Hospital, Indianapolis

THERE will be church hospitals in the postwar world. What should concern us most is the quality of these hospitals. There are financial, scientific, ethical and spiritual standards that should be maintained by these hospitals if they are to have standing in their communities and make their largest contribution to the health of the people.

Church hospitals must have a sound financial policy. If, as some prophesy, there are to be no rich in the "new order" large gifts from the wealthy and well-to-do will not be forthcoming. Undoubtedly there will be an increasing need for hospitalization and possibly a larger demand for free beds.

Church hospitals, however, must adopt some form of controlled charity. I doubt whether a church hospital is justified in doing charity work for which it has no reasonable hope of payment. Even in such good work as ministering to the sick hospitals must have good business management to assure their reputation for financial integrity. Repudiation of financial obligations is not a manifestation of Christian character.

Must Have Only the Best

Church hospitals in the postwar world must rank in scientific standards, in buildings, furnishings and equipment with the best nonchurch hospitals. They should strive to attain even higher standards. Their medical and nursing staffs should be superior in training and efficiency. Anything less than the best is not good enough for the church.

A church hospital should be essentially different from a city or privately owned hospital. Granting that the equipment, furnishings and standards of professional service of other hospitals may be equal to those of the church hospital, the church hospital must have "something extra added." It is this "something extra" that makes it Christian.

Years ago Cotton Mather used a telling phrase, "The angelic conjunction of medicine with divinity." It is this "angelic conjunction" that should constitute the church hospital's greatest contribution to the healing arts.

In recent years there has been a rapprochement of religion and medicine. Seward Hiltner, in his recent book "Religion and Health," reminds us that "during the last twenty years the idea of health as related to the whole personality has been increasingly accepted. What religion does for health, concretely and specifically, is now beginning to receive the attention it deserves. The religious approach has increasingly been put to work by the bedside, in the study, the home, the prayer room and its findings are emerging with a new authority."

Dr. C. G. Jung, the eminent Swiss physician and psychologist, once stated: "I should like to call attention to the fact that among all my patients over 35 years of age there has not been one whose problem in the last resort was not that of finding a religious outlook on life. It is safe to say that every one of them fell ill because he had lost that which living religion bestows and none of them has been really healed who did not regain his religious outlook."

We now know that in all forms of disease the mental and spiritual condition of the sufferer counts much, and in many cases spiritual treatment alone brings results. It would be blind and stupid to deny the high value of scientific methods in the treatment of disease, but it is equally foolish to regard man as a mere physical being and nothing more. The time is at hand when the spiritual nature of man is destined to be given increasingly more consideration in the treatment of his bodily afflictions.

We are on the threshold of a new epoch in the study of health, the mark of which will be the recognition of the close interpenetration of the planes of body, mind and spirit. May it not be that the phenomena of what is sometimes called spiritual healing will be brought within a close scientific synthesis and will have a place given to them in a wider and deeper scientific scheme of healing?

Here is the opportunity of the church hospital. It can add the "something extra," it can offer to the sick "the angelic conjunction of medicine with divinity." It can unite religion and scientific knowledge and skill for the healing of body, mind and spirit. In the postwar world this contribution to the health of the world will fully justify the existence of the church hospital.

Make Them Truly Christian

It is well to remind ourselves that if we are to make this great and significant contribution we must do all within our power to make our church hospitals more truly Christian.

How can this be accomplished? Briefly, I suggest some helpful steps.

The church hospital should have Christian personnel to conduct its affairs. The members of the governing board should be men and women known as honest, religious citizens of the highest type. The staff members should be chosen not only because of their high skill and efficiency but also because they are known as clean, honest men of good reputation, who observe the highest professional ethics.

The school of nursing, while maintaining the highest scientific standards of technical training, must stress along with the training of the head and hands the training of the heart. The student nurses should be made to realize that to be a good nurse one must be a good woman and to be a good woman one must be a Christian woman.

In creating a Christian atmosphere a full-time hospital minister or chaplain can be increasingly effective. Protestant hospitals are only beginning to realize the desirability of having a well-trained minister in charge of the religious work.

From a paper presented at the annual meeting of the National Association of Hospitals and Homes, 1944.

TRUSTEE FORUM

Let's Look Ahead

RAYMOND P. SLOAN

NEVER was there a time when crystal-gazing was quite as popular as it is today. It has become, in fact, the favorite pastime of many. As might be expected, too, each one sees revealed in the clear depths something different—his own interpretation of the world as it is to be in days to come and the rôle he is to play in it. In the process of projecting ourselves into the future what do we find that may serve as a hospital and health pattern.

The whole picture centers about the trustee, a post which carries with it increasing responsibilities these days, for is it not he who must chart the paths of our philanthropic institutions and direct their destinies! How poorly he has been prepared for his task! What could we have been thinking of to overlook him so completely all these years? He has been a guardian in name only.

Too Little Attention Paid Him

So busy have we been in raising standards elsewhere, getting our institutions approved and building to certain professional specifications, that we have given little thought to the trustee's qualifications, attitudes, vision, thinking. It is not his fault if he has remained ineffectual. The importance of his functions has never been completely realized. Little has been done to raise the standards for hospital trustees.

It is all very different in this picture of the future. No longer do we find hospitals gaining approval through measurements applied to their professional staffs alone but through measurements applied to their boards as well. For how can an institution achieve its full potentialities and be thoroughly sound under government that is unstable, unwise, inefficient. We should scrutinize the actions of a hospital board as carefully as we should follow the procedures of its medical staff before saying "yes" or "no."

Fewer but better hospital trustees appear in this postwar picture. Nowhere, or hardly anywhere, do we discover cumbersome boards of 30 or more. Eight or 10 individuals assume the major responsibilities, the rest remaining as friends of the hospital, about whom we shall hear more later. By better trustees is meant trustees better prepared for their responsibilities. Hospital training programs might well start at the top and work down instead of contrariwise. No longer can the trustee remain the forgotten man.

In these men and women we discover a curious combination of realism and idealism. They interpret hospital and medical care as a nonprofit public service. Basic social attitudes and philosophies are far more important than any individual service they may offer as bankers, lawyers, engineers and such. Such counsel can be purchased; social values and ideals cannot. Proper balance between the two is an ideal solution, of course.

These trustees are truly representative of the community, speaking authoritatively in terms of labor, religion, politics, but without bias, discrimination or egotism. They are realists who recognize the need of providing the community with the best possible health service at the lowest possible cost. Consequently they visualize the hospital as a center for medical care and health education providing all diagnostic and therapeutic services. They recognize the potentialities of group medical practice. Their health program is all-embracive, providing for the acutely ill, also for chronic illness, convalescence and geriatrics.

Throughout this postwar picture, groups—community groups, industrial groups, public health groups, hospital groups, medical groups—strive collectively for better health standards. There could be no better slogan for such concerted effort than that which appears under the name of the Maine Hospital Association, "Together, for Others." Those three words which imply so much might well be adopted by every hospital association or council.

Closer integration and regionalization of hospital service are inevitable, with smaller outpost hospitals affiliated with certain larger central hospitals and medical units. In the state of Maine new trails have been blazed in this direction through projects sponsored by the Bingham Associates which center about the Central Maine General Hospital in Lewiston and the Eastern Maine General Hospital in Bangor. Such achievements will spread to other sections.

Noticeably absent from the picture are numerous small hospitals vying with one another for patients and with no apparent good reason for their existence. They continue to serve, some of these, but as part of a carefully conceived health plan.

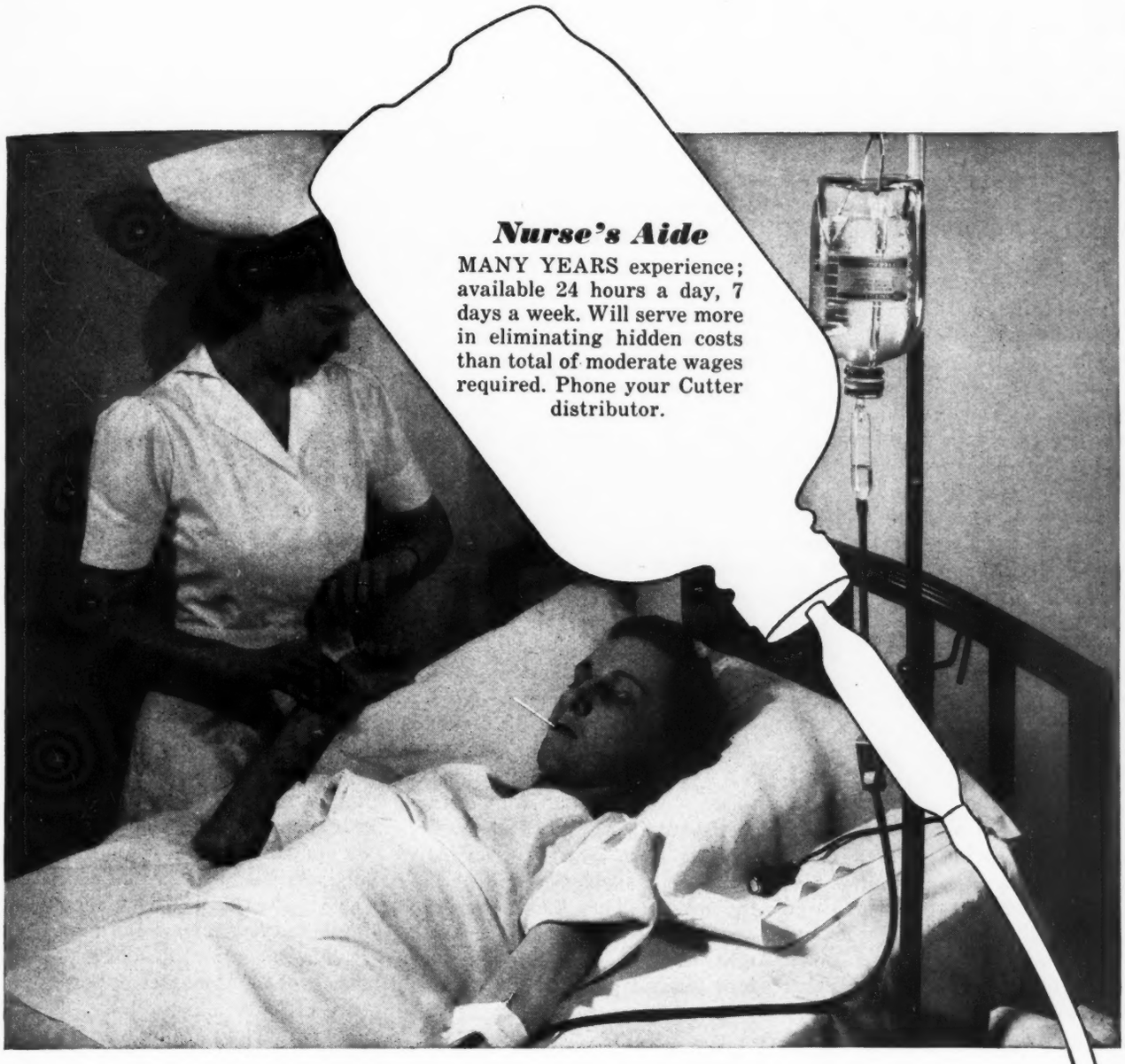
It is to be hoped that the motivation for such group planning may come from within the hospital field rather than from without. And it will, provided we recognize trends and prepare to meet them.

Industry Will Play a Part

Among the groups that play an important part in this postwar program is industry. Already we find industry participating actively in health programs. Henry J. Kaiser of shipbuilding fame in his fine new hospitals on the Pacific Coast, particularly the Permanente Foundation Hospital at Oakland, has produced health—and dollars—through group medical practice.

This is merely a war-time expedient, you say. Mr. Kaiser has provided hospital facilities where there were none, or at best few. True, in one sense, but is it not logical that from many war-time measures we shall evolve patterns that will be lasting? If industrial leaders in this country are convinced that under their auspices and through some sort of medical group practice as set up by Mr. Kaiser better health can be provided for their workers and their families, on a sound economic basis, they will bring pressure to realize it.

From a talk given before the Maine Hospital Association, June 1944.



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A question that should concern us is what would have happened if there had already been adequate hospital facilities in that community where Mr. Kaiser established his Permanente Foundation Hospital.

Group practice in a different form is revealed at the Mary Hitchcock Memorial Hospital in Hanover, N. H., where it is making a definite contribution toward providing proper distribution of adequate medical care on an efficient basis and, therefore, at lower cost. Here the hospital is the physical hub of the wheel. The hospital staff of five men was organized as a group clinic in 1927. Three of the five founders are still in active practice and 17 more have been added. Almost every variety of practice is within the activities of this group. There are no practicing physicians in the local community outside of the clinic.

To go back to industrial support, another trend that obviously is less challenging is revealed in Hartford, Conn., where more than $2,000,000 was obtained from such sources for the building program of the Hartford Hospital. This uses existing hospital facilities as a basis for the health program but without group medical practice.

Perhaps some of these industrial leaders will start asking questions and will influence the more adamant among us to change our thinking to conform with a changing world.

Not only must we do some thinking but we must do plenty of talking about the services of our voluntary hospitals. Comparatively few people know what these institutions actually are accomplishing in research and health education. If ever a press agent, so called, was needed, it is in this field.

Looking into the crystal ball it is possible to see hundreds, thousands, of men and women qualified to present the story of the voluntary hospital speaking before community groups and explaining to them what it is all about. The same procedure applied to voluntary hospital insurance would, without question, help more than anything in boosting membership in our Blue Cross plans and thus eliminate any need of a government system. We need to become audible. For too many years we have sat back and taken what has come. Who shall defend our voluntary hospitals if it is not ourselves?

These men and women—boosters, speakers, publicists for the voluntary system—are now among our volunteers. Already we hear the question raised, "What about volunteers in the postwar era? What jobs can we find for them when paid employes are again available?" Here we have the answer. They know, these men and women who have served as orderlies and nurse's aides. They have learned the hard way, through practical experience. Now let them go out and describe what they have seen, the many needs that they know exist, what voluntary hospital service means to the average man and woman.

Here then is another important group in the postwar picture—volunteers. Of course, we shall always have them; of course, we shall always need them if for different purposes.

We see two types of community groups supporting our hospitals. First, the volunteer group comprising men and women who will render active service of one type or another. In this category will fall the functions of women's auxiliaries, which for so many years have rendered valiant support. Surely there could be no more tireless workers for the hospital than these public-spirited women.

Then there is a second group, an even bigger and broader group, comprising an auxiliary or society of the hospital which will include volunteers as well as those unable to render personal service—supporters of the hospital, nevertheless, who will participate as members through sustaining dues.

It is entirely conceivable that from the ranks of these volunteers and auxiliary members promising material may be recruited for the governing board or trustees. But no action shall be taken until they have proved their worth. Again, fewer but better trustees is our aim.

These various groups, community, industrial, public health, medical, speak in terms of the modern hospital which has previously been described as a medical and health education center. Not only does it provide beds for the sick but diagnostic and treatment clinics, doctors' offices, public health offices and, of course, laboratories for research.

Finally, we behold a great nationwide body of hospital trustees, volunteers and friends constituting public opinion for our institutions. These men and women will speak with authority when our voluntary charities are challenged and will hold regional and national rallies on occasion. They will comprise the privileged, also the underprivileged, men and women from every rank of life, who will serve without bias of race, color or religion. And as their motto they will adopt these words, "Together for others, for the good of all mankind."

VOLUNTEER ACTIVITIES

Too Good for Rummage

The eleventh scholarship for postgraduate nursing study at Evanston Hospital, Evanston, Ill., will soon be awarded from the proceeds of the annual resale of clothing held by the nursing committee of the women's auxiliary. The committee takes over the enormous gymnasium of Northwestern University to display and sell dresses and suits and other garments "too good for rummage."

Juniors on the Job

Trim and brisk in their red and white checked jumpers and caps, 16 junior hospital aides are at work at St. Luke's Methodist Hospital, Cedar Rapids, Iowa, the first group of hospital juniors in the state.

Chosen from a long list of eager applicants from the membership of local Camp Fire Girls and Girl Reserves, the junior aides now doing such satisfactory work in the hospital had ten hours of classroom work and twenty hours of practice before they were capped. They have promised to give a minimum of fifty hours to the institution during the year.

Naturally their duties are nontechnical. They pack and check supplies, clean and sort equipment, carry trays and help feed patients, assist in entertaining children, take care of toys and books and give assistance to the women at the reception desk and help in clerical tasks.

Mrs. Marian Roberts, director of volunteers, designed the girls' uniforms, which most of the girls made themselves with some assistance from their mothers.

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It's Worth the Effort

to train student nurses in the hospital pharmacy

SISTER GLADYS ROBINSON, R.PH.
Milwaukee Hospital, Milwaukee

THE training of student nurses in pharmacology and the mechanics of preparing solutions and medicines is performed by every school or college of nursing but the training of student nurses in the pharmacy is carried on in few hospitals.

The very fact that so few hospitals have student nurses in their pharmacies shows that definite difficulties exist in carrying out such an educational program. Many small hospitals with schools of nursing do not have full-time pharmacists or enough personnel in their pharmacy to warrant developing such training. Then, too, in the present war emergency the departmental training of the student nurse has been cut to skeleton proportions in order to make her available for more floor duty.

There Is Prejudice, Too

Besides these real difficulties certain prejudicial barriers exist in the minds of both hospital pharmacists and nursing school executives as to the value and advisability of such training. Many feel that it is too technical a field for the student nurse and that a little knowledge may be a dangerous thing.

With a thorough knowledge of the difficulties and responsibilities involved in such training, Milwaukee Hospital, Milwaukee, has for many years included it in the departmental service of the student nurse. The student has been in the school from one and one fourth to one and three fourths years when she serves in the department. This means that she has had a large percentage of her theoretical training and has done quite a bit of floor work. This knowledge and her floor experience make her an intelligent and inquiring person in the pharmacy.

It is valuable for the student nurse to spend time in the pharmacy to promote better cooperation and understanding between the nursing staff and the departmental staff. This can be of great value to the pharmacy in many instances. For example, the proper filling out of pharmacy requisition orders by the nursing staff would save much time in the pharmacy and in getting the medicine to the patient rapidly.

By giving this training we pharmacists have a marvelous opportunity to foster appreciation and respect for our profession. This will be of value not only to the individual hospital pharmacist but to the profession as a whole. When the student nurse sees the skills and knowledge necessary to carry on our work, her respect for our profession naturally rises. A better knowledge of the work and the time involved in making up prescriptions will make the nurse more patient and less demanding and will thus decrease possible irritations between the two professions.

Knowledge of and participation in the work in making up certain stock preparations in the hospital often lead the nurse to resolve to be more economical in their use.

Besides giving the student nurse a better understanding of the department and fitting her to cooperate well with it we want to contribute something to her education. This is done by giving her a thorough review of pharmaceutical mathematics and every possible opportunity actually to use this knowledge in making up medications.

At the same time her knowledge of drugs is enhanced by allowing her to help prepare, or to observe the preparation of, prescriptions and stock medicines. The drugs in the prescription and stock medicine are discussed by the pharmacist and student or assigned to the student for further research work. This practice follows an accepted fact of education, the principle underlying laboratory work, namely, that one learns best by handling and working with concrete examples.

This experience enables the student nurse to know where to turn for help in the difficulties and problems that will confront her in her future work with the administration of medicines. She knows that the pharmacist either has the information she desires or knows where and how to get it for her.

Prerequisites for Pharmacist

To be a pharmacist in such a situation carries with it certain prerequisites. One should be a graduate of a recognized college of pharmacy and, if possible, have a master's degree. This will soon be a necessity inasmuch as many of the student nurses even today are college women, having from one semester of college work to four years or more. In the educational background of the teaching hospital pharmacist, such subjects as educational psychology and tests and measurements should be included.

Even with this proper background, the hospital pharmacist should keep up professionally by taking active part in pharmaceutical societies and, if possible, occasionally taking courses at a university. This is, of

Presented at the Tri-State Hospital Assembly, May 1944.

course, easier for the pharmacist in a large city where there is a university or a university extension division with evening classes.

Work with student nurses demands much patience and understanding on the part of the pharmacist. Certainly, one can do things faster if one does them oneself and if one doesn't teach at the same time. The awkwardness of a student making an ointment or mixing something in a mortar often irks the pharmacist. However, with a little practice students do well and are usually painstaking in their work since it must meet the critical eye of the supervising pharmacist.

The tedium and repetition involved in teaching are relieved by the stimulus the pharmacist receives from the constant stream of personalities passing through the department. This is much more satisfying than the ordinary momentary contact one has with the nurses as they come to the pharmacy for drugs. This unending student parade keeps the pharmacist professionally alert and young in attitude.

Besides the value received by the pharmacist and the student nurse, there is great possibility in the teaching program for the intern pharmacist. Here is an ideal opportunity for the intern to develop the ability to handle and teach people.

If we think in terms of responsibility and the monotony of teaching we may be inclined to bar the student nurse from the pharmacy but if we are interested in the future of our profession and in what we have to offer the nursing profession we shall be glad to give her training in the hospital pharmacy.

Pharmacy Is a Science

ALEXANDER W. KRUGER, M.D.
Medical Superintendent, Metropolitan Hospital, New York City

ESSENTIAL unit that it is in the modern hospital organization, the hospital pharmacy has strangely not progressed in scientific development to the degree that has been reached by similar therapeutic units, such as the physical therapy and occupational therapy divisions, or even by such dissimilar units as the dietary department and laundry.

In point of fact, we administrators have—inexcusably in many instances—gradually come to regard our pharmacies as mere points of issue of more or less prefabricated articles, much as we regard our general stores divisions. To attempt to fix the blame for this, shall we say, degenerative trend would be, from a practical angle, beside the point.

It would be instructive, however, to speculate upon the cumulative effect of the practice of many hospitals of underestimating the importance of the pharmacy as it is reflected in their tendency to provide inadequate space and equipment; to offer inadequate salaries, and to obtain, in inevitable consequence, only inadequate pharmacists.

It should be accepted that in the scientific development of the hospital pharmacy we must expect to reap the same relative benefits as we anticipate and realize in the development of those hospital divisions with which we have, in the last twenty years, been particularly concerned. Witness the benefits, yes, financial benefits, derived from the scientific development of our clinical records room with its tremendous aid to medical research.

To the question, "Along what particular lines may such scientific development be expected?" may be offered the following suggestions.

A graduate of an accredited college of pharmacy has had considerable training not only in pharmacy but in pharmacology, in inorganic and organic chemistry and in the basic principles of physics, bacteriology, physiology and zoology. We should, therefore, be able to expect his effective and intelligent participation in any medical research problem that concerns the use of any chemical agent, since the pharmacological element in such research is paramount.

It is often the case in our large metropolitan hospitals that new medicinal agents—newly conceived and synthetized by a pharmaceutical concern—are put into clinical use under proper controls prior to general issue. A properly trained staff of pharmacists should, in such an instance, be invaluable in checking the various pharmaceutical claims and suggesting modifications.

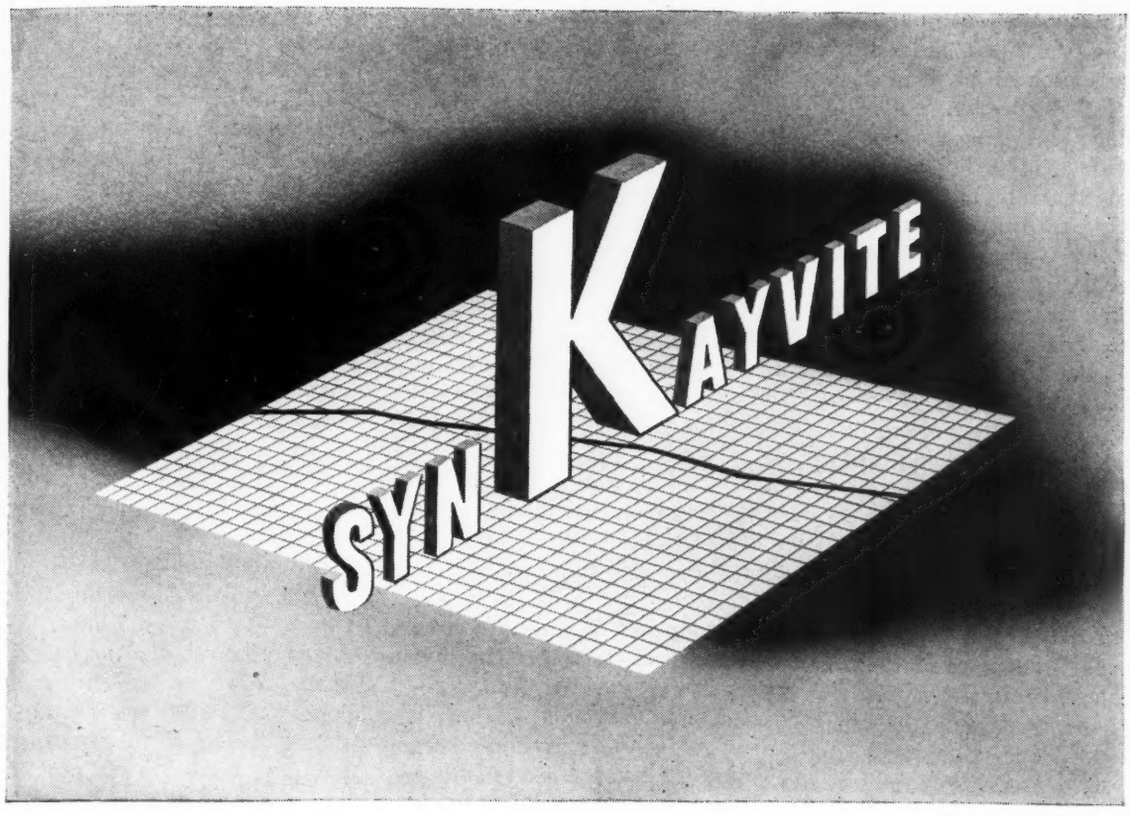
Imagine the advance that would be possible should a staff doctor who has conceived an original therapeutic use for a known drug be able to consult, with confidence, a pharmacist who is not only able but also "scientifically minded" and on his toes and who has proper facilities.

Occasionally, difficulties occur—particularly in these days—in the solutions and washing compounds used by the laundry. A competent pharmacy could then be called upon to analyze the faulty washing mixtures and should be able to point to the fault and suggest a remedy. A research problem in the matter of efficient stain removers would be relatively simple and well within the powers of even the average pharmacy, yet the value in linen salvage is tremendous and quite obvious.

Consider the problem of vermin infestations and the recent difficulties in obtaining efficient insecticides. The properly organized pharmacy should be able to investigate exhaustively the possibilities for a newly conceived insecticide that is at once efficient, economical and readily obtainable (this last point is, however, probably too much to expect).

Often, a pharmaceutical house will offer us a compound or biological at a considerable saving over the similar products of another firm. Equal potency and uniformity are invariably claimed. Such claims can occasionally be checked by relatively simple pharmacological assays, in consultation with the medical staff, which a properly developed pharmacy, such as we envisage, can readily perform.

Constant research in the matter of more efficient and more economical vehicles will, alone, often provide not inconsiderable savings. We had such an instance when, in the recent



TO MAINTAIN NORMAL PROTHROMBIN LEVELS

The complication of neonatal hemorrhage has been found to be abolished in infants born of mothers who have been given vitamin K during labor. Very significant differences have also been observed between the prothrombin levels of those mothers who had received vitamin K and the levels of the controls. For effective routine prophylaxis with vitamin K many physicians depend exclusively on Synkayvite 'Roche.' Synkayvite is a stable, water-soluble vitamin K-compound—one and one-half times as active as natural vitamin K and of markedly low toxicity. Supplied in oral 5-mg tablets and 1-cc ampuls, 5 mg and 10 mg . . . HOFFMANN-LA ROCHE, INC. • NUTLEY 10, NEW JERSEY

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past, our pharmacist devised an ointment base that permitted the use of half the usual concentration of the medicinal agent without in any way diminishing the therapeutic result.

This little problem in research required no considerable outlay of time and no special equipment but required principally only such a point of view as that of our pharmacist, who is being encouraged along these lines and who, moreover, is properly trained.

The same pharmacist, during the past year, has been able to synthetize an antiseptic that is being used increasingly in our operating rooms and is replacing commercially prepared solutions that cost up to ten times as much. In this connection, it would be instructive to note that, in the development of this antiseptic, our bacteriology staff participated to no small degree in the establishment of the phenol coefficients, an instance of intramural cooperation and teamwork.

If we hope to develop the pharmacy to desirable scientific standards, it would seem necessary to advance somewhat the usual position of the chief pharmacist in relation to the medical staff. Although it seems a revolutionary concept, it is nevertheless suggested that, particularly in the larger metropolitan institutions possessing teaching affiliations, the chief pharmacist be made an ex-officio member of the medical board or, at least, of the supervisory medical staff organization. He could then obtain that close contact through which the most efficient staff relationship could be achieved, with inevitably increased efficiency, cooperation and good will.

Efforts could then be made to establish an affiliation with a college of pharmacy with the view of providing pharmacy internships for the graduating class. Such an internship could be made extremely attractive and the value of these neophyte pharmacists in furthering research programs is obvious.

A pharmacist worthy of such responsibility should, of course, have received the best professional education. He should, obviously, be paid a commensurate salary, considerably more than is now paid in many of our large hospitals.

The rôle of the hospital pharmacy as a teaching unit offers large possibilities. The average medical school graduate, while receiving extensive education in pharmacology, is often woefully ignorant of even the essentials of prescription writing. By providing a short, two to four weeks' term in the pharmacy during each internship, every intern could acquire some valuable training not only in prescription writing but also in some of the basic principles and problems in practical prescription compounding.

Incompatibilities would then become realities to him rather than a memorized list, easily forgotten. In addition, he could readily learn of the multitudinous preparations, U.S.P. and N.F., that are available as substitutes for some of the expensive proprietaries. As he learns of the resultant savings to the institution (it could be emphasized to him) he soon realizes with grateful appreciation that he possesses a knowledge that will save money for his patients of the future—an invaluable asset.

In a similar fashion, in those hospitals maintaining training schools for nurses, a short period of training in the pharmacy could be provided to student nurses with equally beneficial results to all concerned.

An equally valuable educational feature would be a regular report by the chief pharmacist on current literature concerning pharmacy and pharmacology. Many an advance in these fields escapes the average physician merely for lack of time to read, however valuable the material may be. Such a duty would result not only in a well-informed pharmacist but also in a grateful medical staff willing to acknowledge the scientific worthiness of the pharmacist.

The value of a hospital formulary is considerable—in theory. It is, however, an unfortunate fact that most such formularies have been of relatively little value, principally because, in too many instances, they represented merely a classified collection of formulas which, while in reasonably current use at the time of compilation, soon fell out of date and out of use, usually for want of proper, constant and able editing.

Our efficient pharmacist not only should have an active part in the compilation of such a formulary but should remain as its permanent editor, always eager to add proved innovations; moreover he should be empowered to remove discontinued or wasteful preparations.

Antisyphilitic Therapy

ARNOLD J. LEHMAN, M.D.
Department of Pharmacology, Wayne University

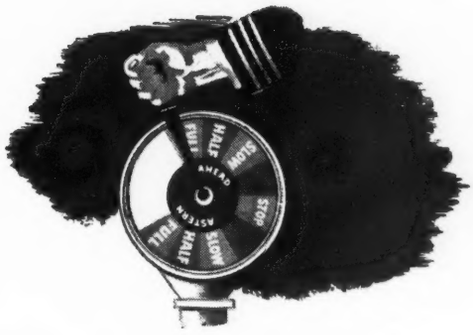
UNDER present standards of antisyphilitic therapy continuous treatment is recognized as superior to the intermittent type. With the former system the infecting organism is kept under constant bombardment and is never free from the influence of a spirocheticidal drug, a condition that does not exist when rest periods are interpolated between courses of treatment. Ample evidence supports the efficacy of continuous treatment.

Continuous therapy may be carried out in three ways: (1) courses of arsphenamine may be alternated with courses of other heavy metal, mercury or bismuth; (2) the simultaneous administration of two types of drugs, such as an arsenical by the intravenous route and a bismuth preparation by intramuscular injection; (3) the administration of a preparation that consists of a true chemical combination of two spirocheticidal agents.

The first method is acknowledged as superior to all others and is the system recommended by the American Cooperative Committee. The simultaneous administration of two types of drugs has its advocates and good results have been claimed for it by its proponents as will be pointed out later.

Therapy composed of the administration of two chemically combined antisyphilitic agents has not been extensively employed because many of the compounds elaborated have not proved very effective. A number of these products are on the market but have received little scientific attention. All contain bismuth in combination with arsenic which exists in the pentavalent form in most instances.

(Continued on Page 92)



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The valency of the arsenic has assumed a measure of importance. Organic trivalent arsenic has been shown to be the most effective agent in early syphilis. The use of pentavalent organic arsenicals was abandoned years ago because of the ineffectiveness of such compounds in the early stages of the disease. However, claims have been made that the arsenic in this form readily penetrates the central nervous system, which may explain the efficacy of tryparsamide in neurosyphilis.

Arsenic in any form has the property of relaxing and eventually paralyzing the contractile elements of the capillaries. These become permeable and actual transudation of fluid can occur as toxic doses are approached. It is possible, therefore, that this mechanism may act to permit the penetration of substances into the tissues that do not possess this property to any extent. It is conceivable that bismuth in the presence of arsenic could enter brain tissue more readily than it would under ordinary circumstances.

Numerous attempts have been made to appraise the various therapeutic systems mentioned. The plan by which an alternation of drugs is permitted has received the most attention and standards of treatment have been laid down by the American Cooperative Committee and by the League of Nations Committee. The system has achieved almost universal sanction.

The administration of two types of drugs simultaneously also has its advocates. Harris (Practitioner **126:** 193, 1931) is a strong adherent to this method and recommends the simultaneous administration of arsphenamine and bismuth. He believes that the presence of one metal enhances the effect of the other as indicated by a smaller percentage of neurorecurrences in patients on this regimen.

Bernard (Bruselles-med. **8:** 1602, 1928) offers additional support for this contention. He followed the spinal fluid titer in three series of cases on different types of treatment. In one series of 85 patients who received arsphenamine only, 74 developed pathologic spinal fluids. A second series of 34 cases was treated with alternating courses of the arsenical and mercury, and 14 showed central nervous system involvement. In the third series arsphenamine and mercury were administered simultaneously and only three of 42 patients showed evidence of neurorecidives.

Belding (Am. J. Syph. Gonor. and Ven. Dis. **25:** 759, 1941) found that in syphilis of long duration a reduction of the blood titer was enhanced by a combination of arsphenamine and mercury. Failure of response to treatment was also lower in those patients who received simultaneous injections of the two drugs than when either was given alone.

In direct contrast to this is the work of Bechk and Barnett (Arch. Int. Med. **63:** 974, 1939) who compared two series of cases. One group received the alternating type of treatment employing an arsphenamine and bismuth and the other received the two drugs simultaneously. The investigators reported that although the incidence of abnormal spinal fluids was the same in the two series the clinical and serologic relapses were greater in the combined series.

Further evidence of the enhancement of the effectiveness of one metal by another was demonstrated by Lehnhoff-Wyld (Ann. des Mal. Ven., August 1924. Ibid. November 1926) who found that the trypanocidal effect of sulfarsenol was greater when any one of a number of metals was administered at the same time than when sulfarsenol was given alone. Kolmer (J. Chemotherap. **6:** 43, 1926) found a similar relationship to hold in syphilitic animals. Small ineffective doses of mercury increased the spirocheticidal action of arsphenamine.

In an attempt to quantitate the effec-

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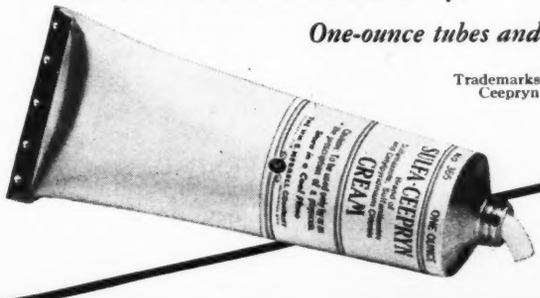

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tiveness of simultaneous arsenic and bismuth therapy in syphilitic rabbits, Clausen et al. (J. Pharm. Exp. Therap. **74:** 324, 1942) employed fractions of the minimum curative doses (M.C.D.) of two trivalent arsenicals and several bismuth preparations. They found that the therapeutic effect was one of simple addition and not potentiation. However, they reported that when 75 per cent of the M.C.D. of a bismuth preparation was combined with 25 per cent of the M.C.D. of the arsenical the additive effect was not as complete as the reverse combination.

Probably the earliest observations on the administration of antisyphilitics existing as a chemical union was the use of silver arsphenamine. A lively literary controversy followed the introduction of this silver and trivalent arsenical combination and certain favorable impressions were reported of it. Cornwall, Bunker and Meyers (Arch. Neurol. and Psychiat. **25:** 137, 1931) observed a greater penetrability of arsenic into the central nervous system following its use than with arsphenamine, neoarsphenamine and tryparsamide. Three to eight times more arsenic was found after injections of silver arsphenamine than with the other agents. A more successful combination has been bismarsen, which unites arsphenamine with bismuth. This product has attained a prominent position as an antisyphilitic.

The simultaneous administration of a pentavalent arsenical with another heavy metal has had some scientific attention. Freund (Klin. Wschnschr. **5:** 1661, 1926) employed vanadium in the form of sodium orthovanadate which was administered intramuscularly every other day. Stovarsol was given by mouth on the intervening days. Superior effectiveness was claimed for this combination in the healing of syphilitic lesions but only a moderate effect on the serologic titer was reported.

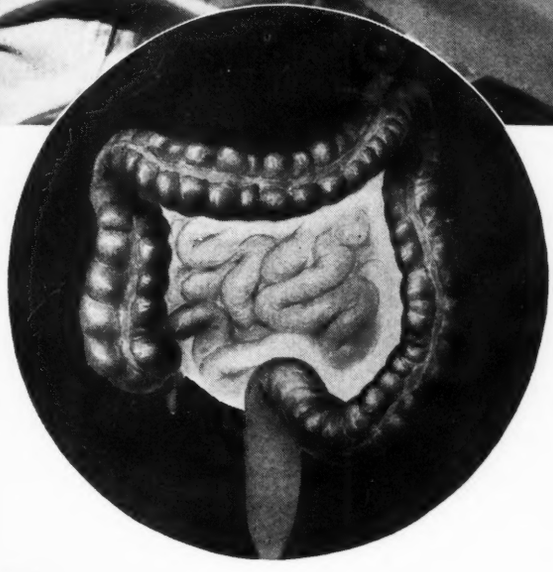
For some years several products have been marketed in which bismuth is chemically combined with pentavalent arsenic and have been recommended for the late stages of syphilis and for Wassermann fast cases. As yet no statement can be made as to the efficacy of such combinations.

One of the immediate drawbacks to the use of these combinations, aside from the known ineffectiveness of pentavalent arsenic in early syphilis, is the possibility of inducing optic atrophy. However, most of these compounds contain from 10 to 15 mg. of pentad arsenic in a therapeutic dose which represents about one tenth the therapeutic dose of atoxyl, a compound recognized as having probably the greatest propensity for producing optic neuritis.

Opponents to combination therapy have also stressed the possible production of drug-fastness. Akatsu and Noguchi (J. Exp. Med. **25:** 349, 1917) have shown that Treponema pallidum can become drug resistant and is able to withstand concentrations of arsphenamine four to five and a half times the original killing concentration when cultivated in gradually increasing strengths of the drug. Mercury tolerance can reach from 35 to 70 times the original strength. A strain of organisms tolerant to arsenic is not necessarily tolerant to bismuth and this is a strong argument for the alternating system of therapy.

Loewy and Wechselmann (Berl. Klin. Wschnschr. **50:** 1342, 1913) believe that combinations of heavy metals may be dangerous especially in the presence of kidney damage. They state that only large doses of arsphenamine alter the vascular apparatus of the kidney, but an organ that has been damaged by mercury is susceptible to even small doses of the arsenical and complete anuria may result under such circumstances.

As a rule, albuminuria is not a prominent feature and a test for kidney



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function is recommended. In this connection Schamberg and Wright state in their text on the treatment of syphilis that the toxic effects of the arsphenamines are on the liver and that of bismuth and mercury, on the kidneys, and, therefore, the same organs do not bear the brunt of both toxic agents. Furthermore, Clausen et al., already quoted, reported that the toxicity after the concurrent administration of an arsenical and bismuth was less than additive, which might suggest a wider margin of safety.

From this discussion it is apparent that the best method for the treatment of syphilis has not yet been established. Any new deviations from the accepted systems engender antagonism and it remains for the future to decide whether antisyphilitics should be administered alternately, simultaneously or as a chemical combination of two spirocheticidal agents. Whether the presence of pentavalent arsenic is an attribute of the newer arsenic-bismuth combinations is still an unsettled problem. It may assist in the passage of bismuth across the hemato-encephalic barrier, but this can only be conjectured owing to the incompleteness of the data.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Thermometer Readings

The authors, DeNosaquo, Kerlan, Knudsen and Klumpp, in an effort to determine what the basis was for the time designations "one minute," "one half minute," "sixty seconds" used on oral clinical thermometers sent out questionnaires and also made a series of studies. The questionnaires were sent to 100 schools of nursing. In answer to the question "What is the minimum time interval between insertion and reading of thermometer?" 27 answered that they allowed less than three minutes, 37 gave three minutes as their reply and the other five of the 69 who answered recommended longer than three minutes.

The other question asked was "Have the time intervals been selected on the basis of the manufacturers' statements, your own clinical tests, common knowledge or some other basis?" Thirteen stated that their time interval was based partially or wholly on manufacturers' statements; 30, on clinical tests; 26, on common knowledge; 16, on textbook statements, and 10, on experience.

Out of 800 thermometers that met with the requirements and tests specified for clinical thermometers, 20 were selected at random. These 20 thermometers were placed in a water bath that was maintained at a constant temperature, each thermometer was read every thirty seconds for six minutes. The temperature of the bath was maintained at 98°, 100°, 102° and 104° F. The mercury rose rapidly and each instrument reached equilibrium within ten seconds.

As ten seconds was considered too rapid a rise to obtain a satisfactory "time temperature curve," an air bath experiment was tried. The 20 thermometers were inserted singly in the air bath which was maintained at a temperature of 106° F. All thermometers reached equilibrium from 94° in ninety seconds. Eight therometers from this group were selected for clinical testing.

Preliminary clinical studies showed that taking hot drinks and smoking produced transitory elevation and cold drinks caused temporary lowering of local mouth temperature. It takes from fifteen to thirty minutes for the temperature to return to "normal." Thirty-two healthy subjects, male and female, white and colored, were used, between the ages of 14 and 20. A total of 493 sets of readings on 5916 individual readings was completed. The average

three minute temperature for the boys was 98.4° and for the girls, 99° F.

In their report, "Clinical Use of Oral Thermometers," in the February 1944 issue of the *Journal of Laboratory and Clinical Medicine,* the authors tell us that the thermometers with specific time designation required the same length of time to reach equilibrium as thermometers with no time designations. Also, that the type of bulb, regular or stubby, did not seem to cause any difference in the time required to reach the "final" reading. The authors tells us, in conclusion, that three minutes should be the minimum time interval allotted for an oral thermometer to reach equilibrium under ordinary conditions of use.—JOHN F. CRANE.

Syphilis Reactions

The problem of falsely doubtful and falsely positive reactions in the serology of syphilis is more important at present than ever before. This is due not only to legally required serologic tests before marriage and during pregnancy but also to the testing of millions of selectees for the armed forces, as well as of thousands of civilian donors of blood. The occurrence of such reactions is always disturbing and places a heavy responsibility upon physicians. The management of patients with such reactions constitutes a practical problem of the first importance.

In the early days following the discovery of the complement fixation and flocculation tests, the falsely positive reactions reported were thought to be due largely to technical errors, except in the case of leprosy and malaria. More recently, however, it has been shown that reactions may occur not only in a number of nonsyphilitic diseases and conditions but also in presumably normal individuals.

The physician cannot place the entire burden upon the laboratory. Certainly, no director of a laboratory, no serologist or technician who is necessarily ignorant of the clinical status of the individual can make a decision as to whether syphilis is or is not present, whether treatment should or should not be given. In other words, serologic tests alone are not sufficient, and reliance must be placed upon the clinical skill and experience of a physician. There is no substitute for thorough clinical examinations skillfully performed.

On the other hand, Kolmer points out in the *American Journal of Public Health,* May 1944, "The Problem of Falsely Doubtful and Positive Reactions in the Serology of Syphilis," that neither can serologists and technicians escape their responsibility. Since there is no single best test for syphilis, serological diagnosis is best served by using two or more approved methods routinely, of which one, at least, should be a complement fixation procedure. Since this is not always possible when large numbers of tests are conducted, a screen test of acceptable sensitivity and specificity is required. All positive reactions should be checked by another method before a report is rendered. Some serologists, including Kolmer, routinely test all serums by a complement fixation, a macro-flocculation and a micro-flocculation test.

A single doubtful or positive reaction without supporting historical or clinical evidence of lues should lead to the withholding of judgment and treatment for at least three to six months, with a repetition of the tests every two to four weeks. If, during this time, the reactions have become repeatedly negative and there are no evidences of syphilis, it would appear that the disease may be excluded. If persistently positive, even though only weakly positive, reactions are obtained, Kolmer makes the point that he sees no escape from the advisability of making a tentative diagnosis of syphilis and instituting treatment. — SIGMUND L. FRIEDMAN, M.D.

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MILDRED WHITCOMB

FOOD contamination is serious trouble wherever it occurs, on a battleship, in an Army camp or in a hospital or other public institution.

Picture a sneak attack on a ship at sea with the entire personnel laid low by an outbreak of food poisoning. Who would man the guns when a weakened lookout in the crow's nest signals the bridge that an enemy vessel is emerging from the darkness off starboard? Not those retching, diarrhea ravaged men who a few hours earlier had eaten heartily of contaminated ham, prepared in an overcrowded galley and left lying at room temperature from 0600 until mealtime at 1100.

A surprise attack and an outbreak of food poisoning have not happened to coincide but don't think such a possibility does not concern the Navy. Cmdrs. Van C. Tipton and Dean F. Smiley, U.S.N.R., have recently recommended, along with closer supervision of Navy food handlers, the use of two separate galleys so that the entire personnel would not be exposed to the hazard of food poisoning at the same time.

What happens in Army camps and naval stations because of someone's carelessness or some slip in the long process of food handling from packing house, dairy, bakery or kitchen to the steam table or serviceman's plate can be and is duplicated in hospitals, restaurants and homes with sufficient frequency and disastrous effect to warrant a review of all food handling practices on the part of dietitians and food service managers.

Let's look at two hospital food catastrophies that occurred last year before considering the subject in more detail.

At Salem, Ore., one fateful day in early 1943, a total of 263 patients at Oregon State Hospital fell ill with varying degrees of violence after a meal that included scrambled eggs. Forty-seven died, most of them in from two to four hours after ingestion of the food.

Two days elapsed before the poison was identified, at which time health officers traced the outbreak to sodium fluoride. A careless kitchen worker had mistaken roach powder for powdered milk and had poured 17 pounds of roach killer into a 10 gallon mixture of scrambled eggs.

Fortunately, scrambled eggs were served that day to only five wards of patients who worked. Many of these rejected the dish because it tasted salty or soapy. Even so the morbidity and mortality recorded there were the highest in medical literature for this type of poisoning.

Usually mass poisonings from sodium fluoride have been due to use of the compound in place of sodium bicarbonate, flour or epsom salts. You may remember the 1940 Pittsburgh story in which roach powder was erroneously added to a pancake mixture in place of flour at a Salvation Army service center.

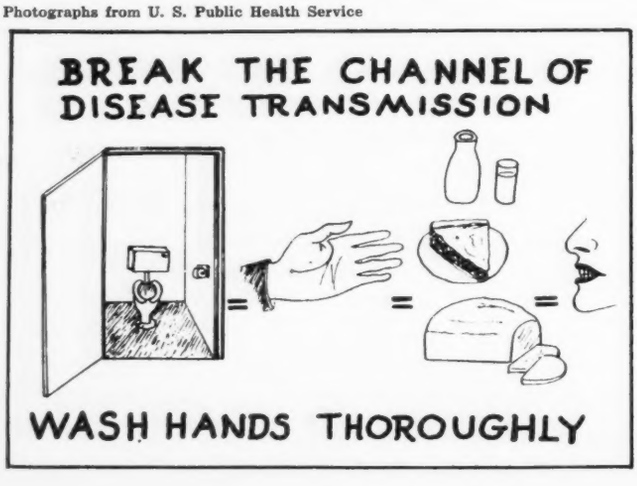
Some states have laws requiring the manufacturers of sodium fluoride compounds to color these substances before their sale. In other states they are still the same menace, since the package bears no poison label and the compound no identifying color. Dietitians need not say to themselves, "It can't happen here" unless they have devised some foolproof method of preventing such a tragedy in their own hospitals.

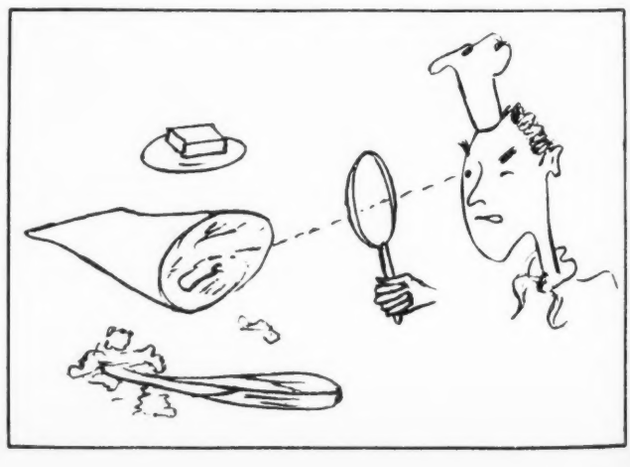
And now let's travel South where a large general hospital in Galveston, Tex., served chicken salad to patients and personnel at a memorable noonday dinner on July 6.

This institution, like some hospitals in other sections of the country, had an inadequate kitchen and outworn equipment and was experiencing the usual war-time personnel problems of high turnover and acute shortage.

There were numerous flies buzzing about the kitchen and some had found their way into the refrigerator. In a small room off the kitchen through a door that was frequently

Photographs from U. S. Public Health Service





opened bits of garbage lay heaped on the floor. For ultimate disposal most of the garbage was hauled away but some of it, including tin cans and similar refuse, was dumped in a pile on the ground less than 200 feet back of the kitchen; many times there was standing water around the garbage dump. Naturally, flies bred there in abundance and mice, rats and other vermin were eager and regular visitors.

That was the setup last year in July. Chickens were cooked on July 5 and were stored in the refrigerator that afternoon and night. Next morning the fowl were brought into the broiling hot kitchen while the salad preparation went on.

Just how that Staphylococcus aureus got on or into the chicken salad has not been established. It may have been introduced from the hands of the kitchen workers; it may have fallen with drops of perspiration; it may have come from floating droplets from someone's nose or throat; it may have been borne by flies, roaches, mice or other vermin; it may have entered through air currents. More than likely it was from human hands.

The cooked chickens went into the refrigerator, which was hardly cold enough to cool the large hot mass introduced, so the infecting organisms had the afternoon and night to multiply as well as the long hours of salad making that went on in the hot kitchen next morning.

Luckily nobody who ate the chicken salad died. Exactly half of the 610 employes who had it were ill; 22 per cent of the 390 patients who had salad on their dinner plates reacted to the poisoning.

Those are two recent outbreaks—one from poison added through error and the other through bacteria unconsciously introduced.

Food contamination, viewed largely, falls into several categories: (1) botulism; (2) bacterial contamination; (3) poisons naturally present in certain foods; (4) poisons occasionally present; (5) parasites of plants; (6) parasites of animals.

Botulism is nothing to worry about these days except in hospitals accepting gifts of home-canned foods or doing their own canning. No instance of botulism poisoning has been traced to a commercially canned food since 1925, almost twenty years. Home canned foods must be adequately cooked (boiled twenty minutes) before serving, preferably shortly before they are eaten.

It is hardly worth the space to discuss poisons that occur naturally in foods, such as mushroom poisoning and that from certain poisonous members of the fish family. If an institution gathers its own mushrooms, the dietitian can inform herself on the poisonous varieties.

Poisons not naturally present in foods include those on fruits and vegetables sprayed with insecticides poisonous to man, the purposeful addition of formaldehyde or copper sulfate at the source, contamination in distribution by means of certain plastic containers which are poisonous or by means of a container that has been previously used for something poisonous, such as vinegar delivered in a barrel formerly employed for white lead shipments. Parasites may be destroyed by proper cooking.

Then there are the occasional outbreaks resulting from food contaminated by silverware cleaned with a polish containing cyanide.

In New York City not long ago there was an outbreak of food poisoning caused by food contamination with cadmium. The foods were acid in nature and were made or kept in cadmium plated utensils. It all came about when certain refrigerator parts were sent in for repairs. Evaporators, grids and shelves were sent to electroplaters and instead of tin plating they were given cadmium plating. Cold drinks became contaminated by ice cubes exposed to drippings or scalings from cadmium plated evaporators and certain acid foods were affected by the same means.

With these brief observations we have left for major consideration only the bacterial contaminants and they are the hazards that need all the intelligence and diligence that a food service manager can summon from her co-workers and kitchen staff. To protect against these unseen enemies requires eternal vigilance.

The two most important forms of bacterial contamination are staphylococcus and salmonella food poisoning, although food-borne streptococcus outbreaks can be devastating, too.

To illustrate the latter point, there was the church reunion in a small New England town where two good sisters volunteered to bake the hams. Those who ate Sister Abigail's ham sandwiches felt no ill effects but the feasters on Sister Samantha's contribution to the supper later developed among them 24 cases of scarlet fever, 56 cases of septic sore throat, 7 of diarrhea and 15 of miscellaneous complaints. When she prepared the ham, Mrs. B was in an early pre-eruptive stage of scarlet fever and infected the meat either with her hands or with her respiratory discharges.

Ham also is a bad actor when it comes to staphylococcal food poisoning. Other foods frequently incriminated include cream-filled or custard-filled bakery products, salt-cured meats (particularly the ready-to-eat hams and beef tongue) and occasionally milk, cheese, gravy, hollandaise sauce, turkeys, eggs and potato salad.

The Navy reports ham as its chief offender. Less often its outbreaks may be traced to milk, chop suey, hash and chicken salad.

Since ham is so often involved in these outbreaks, a few general rules in handling it have been gleaned from the medical literature.

1. Cook hams so as to attain a temperature of 140° to 158° F. at the center of the ham. This necessitates prolonged cooking since even after two hours of boiling, temperatures in the center may still be only 115° to 135° F., according to Dr. Milton J. Rosenau. Four or five hours' cooking is recommended.

2. When removed from the range, ham should be promptly chilled and kept at a temperature not exceeding 45° F. Boning and slicing should not be done more than four hours prior to serving.

3. Contamination in boning and slicing should be guarded against by (a) inspection of kitchen personnel for cleanliness and freedom from

Put trays or baskets with washed dishes in a second sink or vat for sterilizing.
Sterilize. This is the bath that kills the germs.
It is the most important step in your job.

"He wipes his feet on your food."

pustular lesions of the hands and forearms; (b) warning kitchen help against contaminating the food by "sampling" or cough spray; (c) protection from flies.

4. After slicing, the ham should be spread in shallow containers and covered with waxed paper. Each tray, as the ham is sliced, should be immediately chilled and kept in a refrigerator at a temperature not to exceed 45° F. until serving time.

Typhoid, paratyphoid and salmonella infections are filth-borne diseases and clean hands automatically rid themselves of disease germs except for space under the finger nails. The salmonella infections come primarily from the parasites of animals. Both hen eggs and duck eggs may be easily contaminated in the nest with living bacteria. Frozen whole eggs and frozen egg yolks have possibilities of serious contamination, according to Dr. George M. Lyon.

New York City for eleven years examined food handlers for typhoid fever carriers and in that time uncovered exactly 35 carriers, it is reported. The cost per carrier discovered has been estimated at $50,000 each. Yet if Typhoid Mary would have washed her hands and cleaned her nails every time she came from the toilet, she would not have contaminated the food, at least not by typhoid germs.

Flint, Mich., several years ago made public health history when it abolished physical examinations of food handlers as a preliminary to issuance of a work permit and substituted a compulsory course in health instruction for food workers. The health department, of course, still examines food handlers suspected of having a communicable disease but in the first five years of the new plan not a single outbreak of food poisoning has occurred in this overcrowded war area where restaurants are short staffed, help is inexperienced and where many people buy ready-to-eat foods from delicatessens and bakeries.

The Flint plan is being copied in several other cities, notably in Michigan and in Texas. New York City and Detroit are now holding classes but not such extensive courses as the one given in Flint.

Let's see how Flint handles the course. There are four one hour lecture periods; the first lesson is given on the first Monday afternoon and Tuesday evening of every month; the second lecture on the second Monday afternoon and Tuesday evening and so on throughout the month.

Every employer and employe in the food and drink business, whatever its nature, must attend. After the first attendance a temporary work permit is issued. When the full course is completed, a permanent permit is given. If he fails to comply with the teachings the worker must go back for a repeat course or his permit may be revoked.

The first lesson deals with harmful bacteria, stressing the fact that bacteria require food, moisture and the right temperature so as to live and multiply and that, provided with these conditions, multiplication is achieved every twenty or thirty minutes.

Lesson II emphasizes dishwashing, utensil cleansing and general sanitation as an aid to preventing the spread of respiratory diseases. Workers are taught to keep their fingers out of the insides of clean dishes and off the utility end of the cutlery.

Lesson III is on protecting foods from flies, cockroaches and other insects, mice and rats, harmful chemicals and human droplet material. Safe refrigeration is also covered.

Lesson IV completes the series and deals with personal cleanliness, the need for washing the hands well before leaving the toilet room and before handling food. Slides illustrate the talk and later a film is shown developed by the Flint health department and the National Tuberculosis Association. It is called "Eating Out."

In addition to training food handlers, the Flint health department has regulations regarding safe temperatures in refrigerators and dishwashing and rinsing tanks and on general cleanliness in eating places, dairies, delicatessens and bakeries. Licenses are suspended until their sanitary practices are up to standard.

This city-wide situation is described to indicate how hospitals in less enlightened communities can train their own food workers if they will but take the trouble. With labor turnover what it is today formal courses may not always be possible but individual training and strict and close supervision must be undertaken if eating is to be safe for either patients or personnel.

It seems an added shame that an outbreak of food poisoning should occur in a hospital, which should be a model of public health practices in the community. Hospital patients are usually ill enough without the complicating manifestations that arise from acute food poisoning.

One simple rule that might well be enforced is that any kitchen worker with diarrhea should immediately be relieved from duty and not permitted to return until stool examinations prove negative.

Those Summer Suppers

MORE hot days lie ahead and as the heat continues heavy foods have less and less appeal to patients and personnel. Fresh garden produce figures largely and happily in the menus, as do fresh fruits, of course.

Free use of seasonal fruits, however, is being curtailed somewhat as they are proving more expensive than some food budgets will allow. Lucky is the institution that has its own orchards.

Hospitals have found the following recipes have appeal on summer menus, utilizing as they do vegetables and salad greens, the less expensive fruits and a minimum of meat, although adding to protein intake.

Supper Favorite

Yield: 50 Servings

60 slices bread, crusts trimmed
1¼ cups butter or margarine
2¼ quarts cubed American cheese
20 eggs
2/3 cup minced onion
8½-18 ounce cans, commercially mixed vegetable juice

Spread bread with butter or margarine and cut into ½ inch cubes. Place bread and cheese cubes in alternate layers in large baking pan or individual casseroles. Beat eggs slightly; add onion and mixed vegetable juice. Pour over bread and cheese.

Set baking pan in pan of hot water and bake in moderate oven (375°) for fifty minutes. For individual casseroles, arrange on baking sheet and bake at same temperature for only thirty minutes.

Supper Salad for Warm Days

Cover large salad plate with crisp lettuce or other salad greens. Peel and slice one seedless orange and arrange slices on the greens. Center the plate with one of the following:

Chicken or tuna or egg salad
Cottage cheese mixed with seedless grapes
Cooked prunes stuffed with peanut butter

This with toast, muffins or a roll and a hot beverage makes a satisfying meal; only a dessert need be added.

Carrot and Peanut Loaf

Yield: 56 Servings

8 pounds (gross) grated carrots
2 pounds raw chopped peanuts
1 gallon crumbled cornbread
8 ounces sugar
¼ cup salt
1 teaspoon white pepper
16 country eggs or 1½ pounds whole frozen eggs
¼ cup grated onion
1 lemon, juice only
¼ cup chopped parsley
½ cup soup booster

Mix well. Shape into four loaves of 3 pounds each and place in greased pans. Place these in pans containing hot water and bake for forty-five minutes in a 350° oven. Allow one quart of sauce for each loaf. This may be a cream sauce with vegetables, a cheese sauce or a mushroom sauce.

Meat and Vegetable Loaf

Yield: 160 Servings

20 pounds boned mutton or beef
1½ quarts raw carrots
1½ quarts raw celery
1½ quarts raw potatoes
1½ quarts raw onion
1½ quarts raw mushrooms (optional)
1/3 cup salt
1 tablespoon black pepper

The installation shown above is typical of Magic Chef equipment at Thompson and in many other war plants.

War plant with million dollar food volume uses Magic Chef equipment

Cafeterias of the Thompson Aircraft Products Company and Thompson Products, Inc., are the largest purveyors of food in the Cleveland area. The location of the Aircraft Division is such that employees must be fed inside the plants. Two of the plants have four line cafeteria counters plus canteen counters. The cafeteria of these two plants feed 2200 people at one time.

Victory vitamin lunches, with more than a third of the food needed for one day, are suggested by employees. Prizes are given for menus adopted.

The Thompson Victory Vitamin program has aroused nationwide interest and recognition from the National Research Council of the War Food Administration. With this program, Thompson is helping in a major way to promote the in-feeding program sponsored by the government. This program is acquainting thousands of people with the advantages of restaurant eating where food is good and properly cooked. This newly acquired habit will present a real postwar opportunity to restaurants prepared for it.

Inquiries are invited on Magic Chef equipment for present or postwar requirements. Consult your equipment supplier or drop us a line.

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Magic Chef

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LOS ANGELES

3 quarts fine bread crumbs (soft)
14 eggs

Grind together meat, carrots, celery, potatoes, onions and mushrooms. Add the salt, pepper, bread crumbs and eggs. Mix well and form into loaves. Place in greased baking pans. Bake one hour and forty-five minutes at 350° F. Serve with brown sauce. This makes nine loaves, 3⅜ lbs. each.

Baked Spinach

Yield: 30 Servings

1 gallon spinach*
16 eggs, well beaten
1 cup butter or margarine
1 pint milk
½ cup flour

Cook spinach, drain and chop. Add eggs and white sauce made from butter, flour and milk. Place in individual casseroles or in one large pan. Place these in pan of water and bake twenty minutes in a moderate oven.

*This is equal to 2½ quarts, cooked, chopped and drained.

Fresh Lime Sherbet

Yield: Five Gallons

7 pounds granulated sugar
¾ ounce stabilizer
1 gallon water
1 pound Karo sirup
1½ dozen fresh limes (grated rind)
¾ ounce gelatin
1½ dozen fresh limes (juice)
24 ounces lemon juice
2 ounces citric acid
Green coloring
2¾ quarts, unflavored ice cream mix
1½ gallons water

Combine sugar and stabilizer. Mix thoroughly and add the first amount of water. Cook for five minutes or until a thin sirup is formed. Add the Karo. Let stand overnight or until cold. Add the grated lime rind. Let stand one to two hours. Strain to remove all of the rind from the mixture.

Add a small amount of cold water to the gelatin and allow it to soak. Then add 1 cup of warm water and stir until gelatin is dissolved. Add this mixture very slowly to the sirup, stirring constantly.

Add the second amount of cold water, then the lime juice, lemon juice and citric acid. Add green coloring. Let stand in the refrigerator until ready for freezing.

Pour into freezer. Turn on refrigeration and freeze for about fifteen minutes. Ice cream mix should be added after the mixture has started to freeze or about five minutes before removing from freezer. Do not allow any extra whipping after refrigeration has been turned off.

Madeira Cake

Yield: 60 Servings

3 cups shortening
3 cups powdered sugar
12 egg yolks
8 cups sifted flour
2 lemons, grated rind
1 teaspoon salt
¾ cup milk
8 teaspoons baking powder
12 egg whites, beaten stiff

Mix as a batter cake. Add egg whites slowly, last of all. Bake in loaf or square tins.

Baked Green Beans and Bacon

Yield: 45 Servings

7 pounds fresh green beans
½ pound bacon
¾ pound butter or margarine
¾ cup flour
1½ quarts milk
1½ teaspoons salt
¼ teaspoon pepper

String the beans, cut into 1 inch pieces and steam until tender. Make a white sauce by melting butter, adding flour, seasoning and milk, stirring constantly until thick. In a shallow baking dish or steam table pan put alternate layers of beans and white sauce and top with raw bacon cut into 2 inch pieces. Brown in oven.

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DIVISION OF
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TOLEDO, OHIO

Menus for September 1944

Virginia L. Douglass
Free Hospital for Women
Brookline, Mass.

Recipes will be supplied by The MODERN HOSPITAL, Chicago

1 Grapefruit and Pineapple Juice Oatmeal Scrambled Eggs Muffins • Soup Baked Haddock Paprika Potatoes Spinach Indian Pudding, Hard Sauce • Fish Chowder Apple and Celery Salad Bread Pudding With Cream	**2** Tomato Juice Whole Wheat Cereal Eggs to order Muffins • Soup Beef Stew Gingerbread and Applesauce • Cream Soup, Melba Toast Cream Cheese and Pear Salad Maple Tapioca With Cream	**3** Orange Juice Wheat Cereal Eggs Muffins • Roast Duck With Gravy Mashed Potatoes Beets Ice Cream • Tomato Juice Dry Cereal Salmon Salad Prunes and Cake	**4** Grapefruit and Apricot Juice Oatmeal Eggs Muffins • Soup Roast Lamb With Gravy Delmonico Potatoes String Beans Butterscotch Blancmange • Soup Rice and Cheese Loaf, Tomato Sauce Lettuce Hearts, French Dressing Applesauce and Cookies	**5** Prunes Wheat Cereal Eggs Muffins • Soup Vegetable Plate: Baked Potato, Carrots, Cauliflower, Lima Beans Jelly Roll • Soup Potato, Egg and Celery Salad Lemon Jelly With Cream	**6** Applesauce Oatmeal Eggs Muffins • Soup Swiss Steak Mashed Potatoes Broccoli Caramel Custard • Soup Assorted Sandwiches Fresh Fruit Salad Brownies
7 Tomato Juice Wheat Cereal Eggs Muffins • Soup Lamb Fricassee Baked Potatoes Beets Ice Cream • Soup Mixed Vegetable Salad Pears, Cookies	**8** Prune Juice Bran Cereal Eggs Muffins • Soup Baked Cod Paprika Potatoes Spinach Grapefruit Snow Pudding, Custard Sauce • Fish Chowder Cottage Cheese Salad Apple Betty With Cream	**9** Orange Halves Oatmeal Eggs Muffins • Soup Meat Loaf Parslied Potatoes Mashed Squash Floating Island • Soup Cheese Fondue Mixed Greens, French Dressing Peaches and Cream	**10** Prunes Wheat Cereal Eggs Muffins • Creamed Chicken Mashed Potatoes Wax Beans Ice Cream • Fruit Juice Dry Cereal Apple-Date Salad Lemon Meringue Pudding	**11** Grapefruit and Pineapple Juice Wheat Cereal Eggs Muffins • Soup Roast Lamb With Gravy Mashed Potatoes Carrots Ice Cream • Soup Egg Salad Applesauce and Cake	**12** Grapefruit Sections Oatmeal Eggs Muffins • Soup Vegetable Plate: Baked Potato, Cauliflower, String Beans, Sliced Tomato Apple Tapioca With Cream • Soup Cream Toast and Jelly Lettuce Hearts, Russian Dressing Prunes and Cookies
13 Applesauce Whole Wheat Cereal Eggs Muffins • Soup Liver Parslied Potatoes Stewed Celery Chocolate Blancmange With Cream • Oyster Stew and Crackers Creamy Rice Pudding	**14** Prune Juice Bran Cereal Eggs Muffins • Soup Creamed Dried Beef Mashed Potatoes Broccoli Ice Cream • Soup Assorted Sandwiches Lettuce and Tomato Salad Coffee Gelatin With Cream	**15** Tomato Juice Wheat Cereal Eggs Muffins • Soup Baked Haddock Paprika Potatoes Spinach Grapenut Custard • Fish Chowder Cream Cheese and Pear Salad Chocolate Icebox Cake	**16** Grapefruit Juice Bran Cereal Eggs Muffins • Soup Meat Pie, Mashed Potato Top Cottage Pudding, Pineapple Sauce • Soup Creamed Eggs on Toast Lettuce Hearts, French Dressing Peaches and Cake	**17** Prunes Wheat Cereal Eggs Muffins • Lamb Chops Parslied Potatoes Squash Ice Cream • Tomato Juice Dry Cereal Small Egg Salad Applesauce and Cake	**18** Orange Halves Oatmeal Eggs Muffins • Soup Pot Roast With Gravy Mashed Potatoes String Beans Baked Indian Pudding With Cream • Soup Baked Macaroni and Cheese Carrot and Celery Salad Prune Pudding
19 Tomato Juice Entire Wheat Cereal Eggs Muffins • Soup Vegetable Plate: Baked Potato, Beets, Spinach, Celery Hearts Jelly Roll • Soup Spaghetti, Tomato Sauce Lettuce Hearts, French Dressing Cantaloupe	**20** Prune Juice Wheat Cereal Eggs Muffins • Soup Meat Loaf Escalloped Potatoes Carrots Creamy Rice Pudding • Soup Assorted Sandwiches Fresh Fruit Salad Orange Tapioca With Cream	**21** Apple Juice Oatmeal Eggs Muffins • Soup Lamb Stew Ice Cream • Soup Asparagus on Toast Mixed Greens, French Dressing Baked Apples With Cream	**22** Grapefruit Sections Wheat Cereal Eggs Muffins • Soup Baked Cod Paprika Potatoes Broccoli Butterscotch Blancmange With Cream • Fish Chowder Scrambled Eggs Apple and Celery Salad Caramel Custard	**23** Orange Juice Oatmeal Eggs Muffins • Soup Chicken Pie, Mashed Potato Top Lemon Snow Pudding, Custard Sauce • Soup Cream Toast and Jelly Lettuce and Tomato Salad, French Dressing Peaches and Cookies	**24** Prunes Bran Cereal Eggs Muffins • Roast Lamb With Gravy Mashed Potatoes String Beans Ice Cream • Broth Canned Fruit Salad Cake With Icing
25 Tomato Juice Wheat Cereal Eggs Muffins • Soup Meat Patties Mashed Sweet Potatoes Spinach Bread Pudding • Cream Soup, Melba Toast Fresh Fruit Salad Butterscotch Tapioca	**26** Apple Juice Wheat Cereal Eggs Muffins • Soup Vegetable Plate: Paprika Potatoes, Swiss Chard, Hubbard Squash, Lady Cabbage Dutch Apple Cake, Lemon Sauce • Soup Cheese Fondue Lettuce Hearts, Russian Dressing Prune Whip	**27** Grapefruit Juice Oatmeal Eggs Muffins • Soup Liver Parslied Potatoes Carrots Jelly Roll • Soup Assorted Sandwiches Apple and Celery Salad Pears and Cookies	**28** Prune Juice Bran Cereal Eggs Muffins • Soup Lamb Fricassee Mashed Potatoes Beets Ice Cream • Soup Baked Macaroni and Cheese Lettuce Hearts, Russian Dressing Coffee Gelatin With Cream	**29** Orange Juice Wheat Cereal Eggs Muffins • Soup Baked Haddock Parslied Potatoes Stewed Tomatoes Floating Island • Fish Chowder Egg Salad Baked Apples and Cake	**30** Grapefruit Sections Bran Cereal Eggs Muffins • Soup Meat Pie, Mashed Potato Top Peach Betty With Cream • Soup Fruit Salad Frosted Cup Cakes

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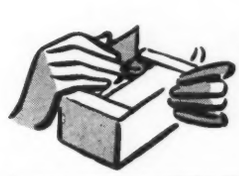

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Locating the Boiler Plant

To find an ideal location for the boiler plant is practically impossible. One consideration must be weighed against another so that building occupants will be comfortable and supplied with hot water without being conscious of the running machinery

EDWARD W. THODE
Architect, York and Sawyer, New York City

IN DEVELOPING the plan for a hospital one of the units to be considered is the boiler plant. From the architect's standpoint, the following points should be considered: (1) appearance, (2) economy, (3) convenience, (4) flexibility and (5) safety.

If the institution is made up of several buildings, the question of appearance is of more importance than in the unit type of hospital. Boilers are most frequently housed in a separate building on a low point of the grounds, to permit the use of gravity returns. As the main buildings are usually three or more stories high and as the boiler house is a low building on low ground, a tall chimney is required. This chimney is bound to be conspicuous because of its height and may stand out so that it dominates the entire group of buildings. Usually funds are not available for giving the chimney an adequate architectural treatment and frequently it develops into an eyesore not only to the hospital but to the entire community.

Inconspicuously Located

Therefore, an effort should be made not only to design the boiler house and the chimney properly but to place them, if possible, on the most inconspicuous part of the property. It may be even worth while to abandon the use of the lowest part of the grounds and gravity returns to take advantage of an inconspicuous location, possibly on the side of the property away from the important streets or in a spot shielded by trees or other building. They should also be located so as to be inconspicuous from those parts of the interior of the building that house patients and personnel.

In the one-building hospital the location of the stack is naturally controlled by the boiler room, it being desirable to eliminate long horizontal runs in the breeching from the boilers to the stack. With proper study it is possible to locate the flue so that it may be incorporated in the architectural design, for no matter where it is placed it must be high and will be conspicuous.

A central location at a low level is usually desirable to shorten the runs of pipes and to permit the use of gravity returns. However, attention should be given to the fact that many other units of the hospital also require central location and the claims of the boiler room to this desirable spot should be carefully weighed.

The low level also is a point to be considered. Usually the boiler room requires considerable head room and the "low level" requirement places it well below grade. This frequently requires a deep excavation, which is particularly uneconomical if rock or bad water conditions are encountered. The great first cost of an expensive rock excavation or waterproofing job may easily offset the future economies of the low location.

When it comes to convenience, two factors are to be considered: easy access to the street or adjacent roads and easy access to all points in the building or buildings. Too often buildings are planned so that it is difficult to bring fuel to the boiler plant or to remove ashes. Sometimes it is necessary to provide and to maintain at considerable expense a long service road solely for this use.

Too often when replacements are required it is found impossible to get bulky apparatus up to the building and even into the building itself. A large window or areaway placed at the correct spot may save its cost many times over when replacements are needed.

As the engine room crew usually does maintenance work throughout the building, easy access to the interior is essential, with shops conveniently located both for engine room and other maintenance work.

Provision for Expansion

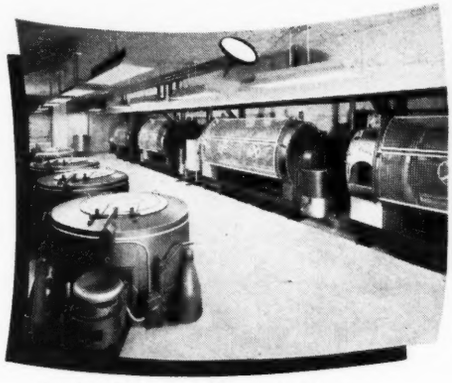
In considering flexibility we must consider the probable growth of the institution and expansions resulting from changes in the demands of medical service. It is a difficult problem to know just how to provide for expansion. Some boiler rooms in old buildings would seem to be the only area liberally planned. Investigation has shown, however, that this apparent waste space was left for future apparatus that was never installed.

The ideal condition is to provide space for present needs in a location that will permit additions to be made to the building as space is required for expansion. Or it is even better to allot some space adjacent to the boiler room to a department that may readily be moved, so that when expansion is required the space will be available for boiler room needs. Bear in mind there is probably no part of a building more difficult or expensive to move than the boiler plant.

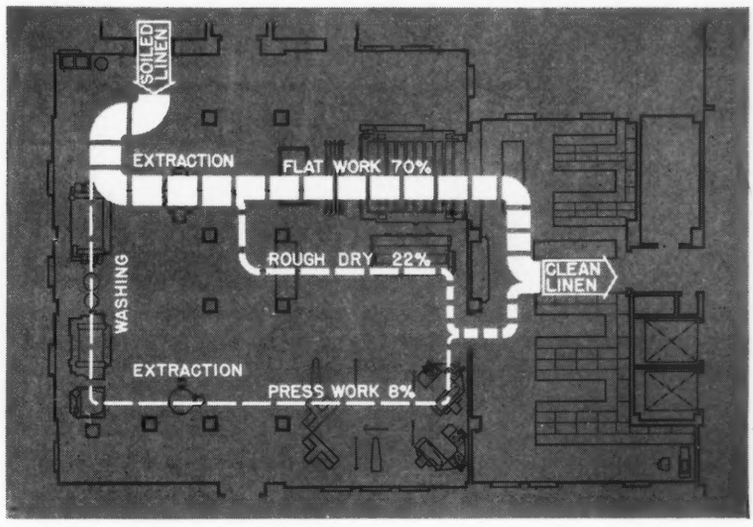
From the standpoints of safety,

PLAN YOUR HOSPITAL LAUNDRY *with* HOFFMAN *NOW!*

Efficient Laundry Layouts Don't Just Happen



Wesley Memorial Hospital, Chicago



Roosevelt Hospital, New York City

WHEN you see a laundry that's properly planned to provide a smooth flow of work with a minimum amount of retracing of steps, you see the result of careful planning. From an operating standpoint, the hospital laundries installed by Hoffman are notably successful. When you call Hoffman to assist in the important job of planning the layout, you assure highest output with a minimum of labor to tend the machines – a smooth forward flow of work that means real economy of operation.

Now is the time to plan your post-war hospital laundry. Then you'll be ready to act when all the equipment required is again available. Experienced Hoffman technicians are available now – to survey your needs and make recommendations.

But Hoffman does not stop here. When you have installed Hoffman equipment, we are prepared to advise on efficient linen controls and laundry operation. We furnish maintenance manuals and lubrication data and render prompt service on replacement parts. Experienced Hoffman servicemen are available to help you keep your equipment in top condition.

So when you plan with Hoffman, you plan well . . . Write, wire, or phone us.

Skilled Technicians—at your service

U. S. HOFFMAN MACHINERY CORPORATION
107 Fourth Ave., New York 3, N.Y.

COMPLETE LAUNDRY EQUIPMENT SERVICE FOR THE INSTITUTION

health and quiet the separate building is ideal. However, the location of the plant within the hospital need not be particularly hazardous. Certainly, no precaution should be neglected that will eliminate dangers of explosion, particularly from oil or gas burners.

If all the necessary safeguards are provided, the location of the boiler room is secondary. However, the location of the flue is important. It should be placed so that prevailing winds will carry the gases away from the building and it should be of such height that combustion will be of the best. An improperly located flue will bring gas and dirt into the building and will develop unhealthful conditions.

The noise factor must also be considered. Nothing can be more disturbing than frequent deliveries of coal or ash removal near patients' windows. The use of oil as a fuel has helped to remove this complaint but, as many institutions still necessarily use coal, it cannot be disregarded. To handle coal and ashes noiselessly is an impossibility, but if the deliveries and removal can be made in a secluded location, the disturbance will be reduced.

A Calculator Saves Time

V. W. PALEN
East Pittsburgh, Pa.

PLANT engineers and electricians will find the KVA-KW-HP calculator a very useful gadget to have on hand; it saves much time in making routine calculations involving electrical capacities. It solves single and three phase problems expressed by the following formulas:

1. Single phase:

$$\text{Kva.} = \frac{\text{Volts x Amps}}{1000}$$

$$\text{Kw.} = \frac{\text{Volts x Amps x P.F.}}{1000}$$

$$\text{H.P.} = \frac{\text{Volts x Amps x P.F.}}{746}$$

2. Three phase:

$$\text{Kva.} = \frac{\sqrt{3}\ \text{Volts x Amps}}{1000}$$

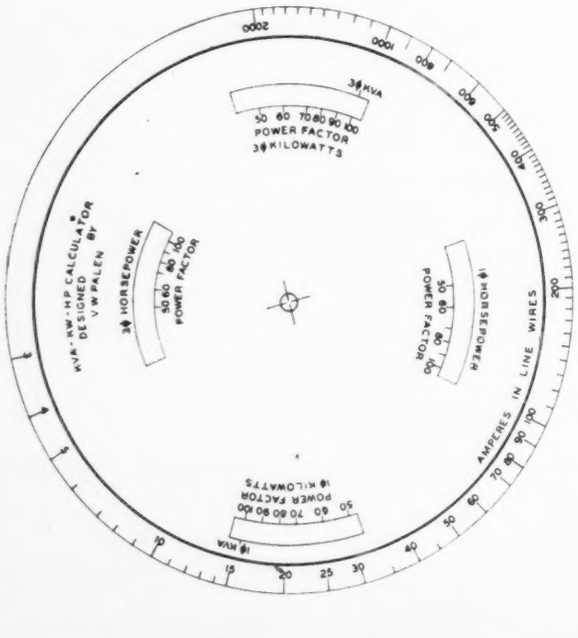
$$\text{Kw.} = \frac{\sqrt{3}\ \text{Volts x Amps x P.F.}}{1000}$$

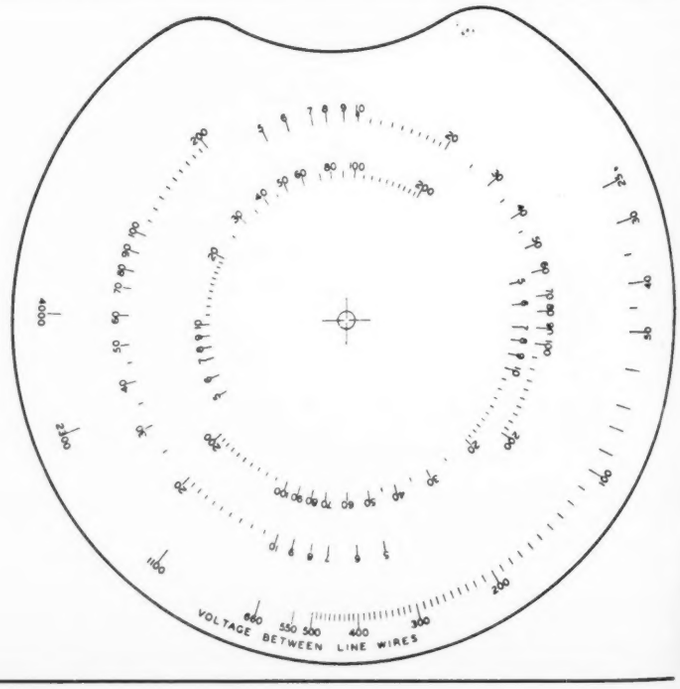
$$\text{H.P.} = \frac{\sqrt{3}\ \text{Volts x Amps x P.F.}}{746}$$

The range of the calculator, 5 to 200 (kva., kw. or h.p., as the case may be), can be extended easily to cover a range of 50 to 2000 merely by multiplying all values by 10. It can be used to find kva., kw. or h.p. from known values of amperes and volts; similarly it will determine amperes for given values of voltage, kva., kw. and h.p.

Thus, knowing the size motor to be installed, an electrician can quickly determine amperes; from this he knows what size wire to use for the circuit. Conversely, having read amperes at transformer terminals, he can learn from the calculator what load, in kva., the transformer is carrying.

To assemble, cut out both disks (also small windows) and mount on cardboard with rubber cement. Punch the center holes carefully, then insert a small brass bolt in the holes. Washers, if used, will save wear and tear on the paper. The bolt should be tightened to give the proper pressure on the disks; they must hold their setting, yet turn easily. A drop of solder applied to the nut will make the assembly permanent.





ENGINEERS' QUESTION BOX

Stripping Paint From Furniture

Question: What is an efficient method of removing excess paint from furniture and equipment?

ANSWER: Build a tank 9 feet long, 4 feet wide and 30 inches high with walls 5 inches thick. It is preferable to build it of concrete of fairly rich mixture like one part cement, two parts sand and three parts aggregate. The aggregate may be crushed stone or cinders; if cinders are used turn the hose on the pile and wash out the dust.

The whole form for the tank should be set up complete and the pouring should not be stopped until finished. A few iron rods or old small pipe may be used to reenforce the sides. Keep the top from drying too fast with wet bags. Remove the form as soon as possible and smooth out the rough concrete with a rich mixture of cement and screened sand. Also add a little waterproofing in the finishing mixture.

A drain pipe must be set in the bottom of the form terminating in an elbow flush with the bottom. Into this can be secured a piece of pipe as overflow to control the water level. When the tank is to be drained the pipe is unscrewed.

If the tank is to be used in cold weather a heating coil should be installed, as the solution to be used is near saturation point at average temperature. Heating the solution will also speed up the work.

Put into the tank 400 gallons of water and a 250 pound drum of caustic potash and when the potash is dissolved, furniture of any description may be thrown in and the paint removed. When the paint is dissolved the furniture is taken out with iron hooks and a hot water hose with good force, together with a broom, will remove the last traces of the paint. When putting in instrument cabinets with glass, the solution should not be too hot. The glass must also be reputtied.

As will be observed, the tank is large enough so that bed springs can be put in. Aluminum and veneer doors cannot be put in the tank.

If paint spraying equipment is available, the whole process can be put on a forty-eight hour schedule with a good slow drying synthetic lacquer. Less time will be needed if nitrocellulose lacquer is used.

There is scarcely any equipment more valuable to an institution than a paint stripping tank and paint spraying equipment.—W. B. TALBOT, M.D., *superintendent, and* LORENTZ A. WESTIG, *chief engineer, New York Post-Graduate Medical School and Hospital, New York City.*

HOLTZER-CABOT
Staff Registers

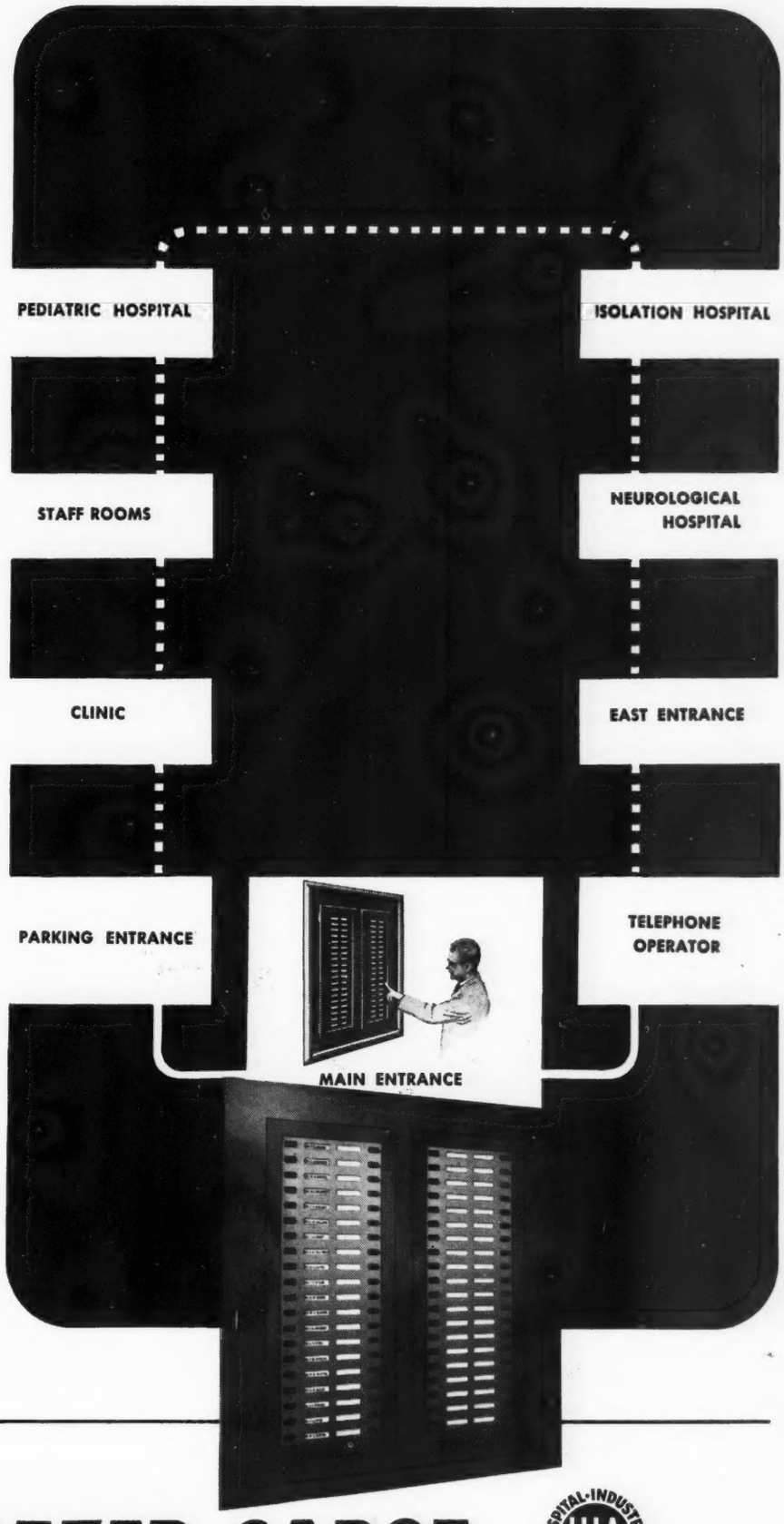
Holtzer-Cabot Staff Registers provide quick, easy indication of presence or absence of doctors in hospitals. When a doctor enters the building, he turns the switch opposite his name on the staff register. A lamp lights behind his name and stays lighted until he snaps it "off" when he leaves the building. Auxiliary registers, installed at various entrances or in separate buildings also light up the same name at all registers.

Telephone operators can signal a doctor that message awaits him by turning the switch opposite doctor's name to "call back" position. This causes a light to flash "on" and "off" until he has called the telephone operator.

Holtzer-Cabot engineers are always available for consultation on all hospital signal system problems whether they be for new installations or extensions to existing systems. Ask for their services.

Catalog, giving complete information on Holtzer-Cabot Hospital Signalling equipment, such as Nurses' Call, Visual and Voice Paging, Staff Registers, Return Call, etc., will be sent on request.

One Responsibility — Satisfactory Operation of Complete Systems.



HOLTZER-CABOT

Division First Industrial Corporation

Pioneer Builders of Signal Systems Since 1875

400 STUART STREET, BOSTON 17, MASS.

Engineers Located in Principal Cities

Conducted by Alta M. La Belle

They don't forget
When They Have a Handbook

THE dreams of nearly every housekeeper these days are haunted by the phrase, "I forgot"—that ubiquitous alibi that is so blandly presented whenever an errant employe is called to account for some neglected task. And the sad part of it is—he probably did forget, for even the brightest and best of employes, especially when they are new on the job, cannot always remember all the details of their various duties.

It has been proved—and recently stressed in Training Within Industry courses—that verbal instructions alone are not enough. They are too easily forgotten, so how about putting them down in black and white? Of course, if the employe can't read that complicates matters, but in most cases a handbook outlining lists of duties, cleaning schedules, hospital rules and regulations and other pertinent information that every employe should know can be very helpful in reducing the "I forgots" to the irreducible minimum.

Such a booklet has been prepared by **Sarah Meffert,** matron housekeeper of the nurses' home, University of Minnesota Hospitals. It is presented to each new maid with instructions to study it and keep it handy for reference. In addition to work schedules, Miss Meffert has included in her handbook a list of equipment that the maid is expected to use and where it can be found; the Sunday and holiday schedule, and several helpful suggestions regarding health and physical fitness.

Recently, she has added a section listing the perquisites that are offered to the maids which help to "sell" them on the job. These include hospitalization, retirement fund, paid vacations and seniority rights on preferred phases of the work in each building.

The booklet consists of approximately 20 typewritten pages, 4 by 6 inches, stapled together. The cover is a colorful photograph clipped from a magazine. Simple, isn't it? But its simplicity and the succinct wording of the instructions make it that much easier for the employe to comprehend.

Just to give you an idea, here are some of the pages from the handbook as Miss Meffert has it set up at the present time:

DAILIES

A "daily" is a room that gets attention every day. Make up the bed, wash the sink and tub, if any, tidy up the room, dust the window ledge and radiator, empty the basket, shine mirrors, vacuum the rug.

Leave the room orderly and presentable.

WEEKLY CLEANING

Weekly cleaning is done by given schedule or on a "move." If someone is occupying the room, only one clean sheet is put on the bed; the lower one is removed. Cleaning must be done thoroughly. Use whisk broom and brush cloth-covered chairs; take down wisps of soot webs; wash the floor and outer window sills; dust thoroughly, including hanging pictures; vacuum the rug.

HOUSE CLEANING

Shake and brush the draperies; put fresh linen on bed; wipe the springs and slats of the bed. Brush down webs of soot and spider webs. Wipe out closet wells, also bureau drawers and backs of all pieces of furniture. Remove finger marks on woodwork, wipe floors, dust thoroughly. Vacuum the rug on both sides; take it out into the hall.

Leave the sink absolutely clean and nickelware shining.

WHEN AND HOW

Watch draperies at windows; either dust and shake them or have them laundered.

Wash windows on the inside; test them yourself.

Watch the woodwork.

Toilet rooms, including bowls and bathtubs, are done every day. The weekly cleaning of toilets must be done thoroughly. Floors and showers are to be scrubbed; use cleaning and deodorizing powder for toilets.

The houseman has a schedule for mopping the corridors but at the end of the day it is up to you to remove small particles of fuzz with your wide broom or wide white mop.

In preparing your dust cloth, moisten it first with water, then saturate it with the furniture polish.

When washing windows, ask for some household ammonia; put several drops in each pint of water or ask for the bottle and sprayer fixed with ammonia water.

When a notice is posted or you are told that a nurse is moving, it is called a "move." Clean the room thoroughly. Wash the bed springs and slats; perhaps the mattress needs brushing and wiping. The bed should have fresh linen, bed pad and spread. Put in clean towels and a new bar of soap.

Let the housekeeper or office know that the room is ready.

If the room cannot be done up within twenty-four hours, let housekeeper or office know!

EQUIPMENT

Every floor has two service rooms and two linen closets. Service rooms contain carpet sweepers, mop, broom, pail. In the wall is a door to an incinerator for burning rubbish.

Newspapers are picked up only from the wastebaskets in the room and are placed on the floor of the service room and picked up later by the houseman.

There are containers holding cleaning powder and on the shelf is a bottle of furniture polish.

In the linen closets you will find vacuum cleaners; clean the bags regularly. There will be a week's supply of linen on the shelves, also yellow and white soap and paper toweling. A paper towel is placed at the bottom of each wastebasket.

Nurses are given a white bar of soap once a month. Unless the nurses use

the scraps of soap, please collect them and use them for your woodwork—but use white soap only. Yellow soap is used on bath floors only.

The houseman will give you small requisition sheets every two weeks. You may order supplies, such as soaps, furniture polish, blue can of cleanser, toilet paper, paper toweling, 25 watt bulbs.

You will find a sponge handy for washing the outer window sills.

The flat linen is delivered to your floor on Thursday mornings. Kindly get it unpacked as soon as possible.

On Thursday after lunch you may request bedspreads, bed pads, blankets and cleaning rags at linen room No. 135. These may also be obtained on other days if the supply in the linen room has held out.

The bags in which the flat linen comes are thrown down the linen chute so that they can be used again for bagging the linen next week.

On Saturday morning the fresh uniforms are delivered to your floor. Remove the uniforms from the bags and keep the bags for Monday morning when, at 7 o'clock, you collect the laundry books, the nurses' soiled uniforms and your own. A bag is needed for both sides of the floor. These bags are collected before 7:30. Your uniform is returned to the maids' kitchen on Saturday morning. Have it well marked. . . .

SUNDAYS—HOLIDAYS

Every maid takes her turn by alphabet and works Sundays. She comes at 7 or 8 a.m. and works for four hours, brushing and tidying up the sitting rooms, lounge and corridor. There will be "moves" and maybe some guests listed.

The usual routine should be followed on the "moves." Put fresh linen in a room that has been vacated by a guest and tidy the room.

The "dailies" for Sunday are usually 321 and 339.

On holidays the same hours and routine of tidying the rooms are followed. Guests may be listed but there are seldom any "moves" on holidays.

"Dailies" would be 339 and 391 and other minor assignments.

The maid for whom you are substituting is in your place on the alphabet for Sunday work.

FOR YOURSELF

Try to keep physically fit on your job for your health's sake.

Do you, can you, rest an hour when you get home? Learn to relax for at least fifteen minutes if you can't spare an hour.

Do you have at least a glass of milk a day? If whole milk is too fattening, drink skim milk or buttermilk.

You might bring something extra along for lunch that can be warmed up, such as soup or an egg or wieners.

Bring oranges or grapefruit whenever you can; they act as alkalizing agents and build up your resistance against colds or rundown condition caused by acids.

Are you dressed comfortably while working?

Keep in mind the correct movements when bending, stooping and reaching. Many wrong movements cause backache, sore muscles or strain.

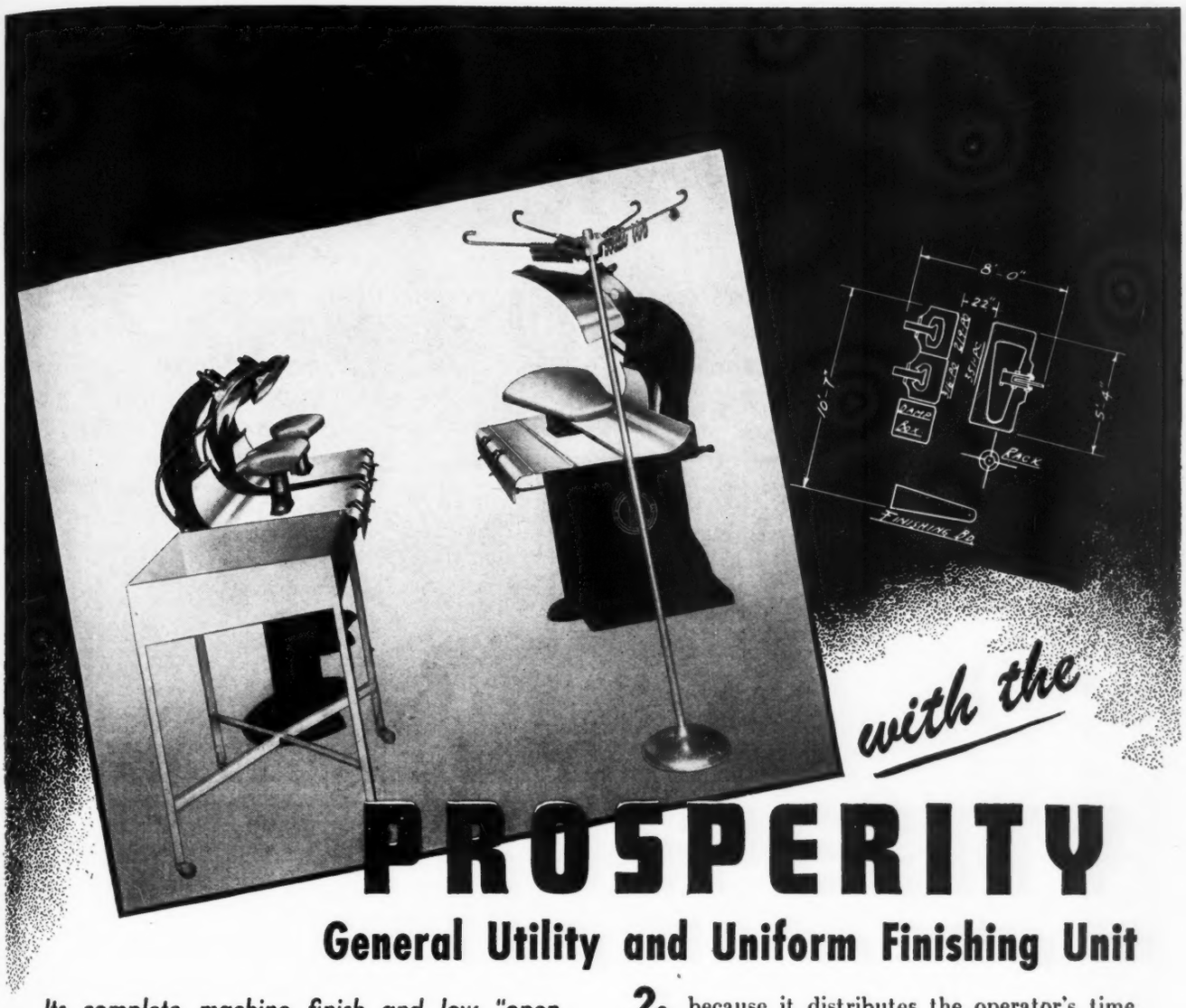
Keep the heels of your shoes straightened or you will find yourself needlessly tired.

MISCELLANEOUS

Articles of clothing, shoes or other items left in either a vacated room or service rooms are to be turned over to the housekeeper for disposal.

Magazines found in wastebaskets are yours if you want them; otherwise, place them with the newspapers on the floor in the service room.

Your lunch period starts at 11:30 a.m. Your dining room is No. 139, which is on first floor east.



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PROSPERITY

General Utility and Uniform Finishing Unit

Its complete machine finish and low "open press" time give a greater volume of better finished work in fewer work hours.

The Prosperity General Utility & Uniform Finishing Unit will keep your laundry and labor problems at a minimum and help you to solve troublesome budget and space worries:

1. because it decreases both the floor space required and the number of steps taken by the operators.

2. because it distributes the operator's time more evenly, thus providing more time for skillful and careful laying of each garment.

3. because there's less "open press" time, hence more output per hour.

4. because there's no costly hand ironing.

The large 351-PC press finishes skirts and the large areas of uniforms and aprons, while the utility shaper bucks on the 316-PO and the 219-PO presses enable you to machine finish yokes, shoulders, collars, caps and the other hard-to-reach areas.

Get in touch with our engineering specialists today. Let them help you solve your washing, finishing, waste of supplies, or any other difficulties that are keeping your costs high and your production low. They'll show you how to get more production with fewer man hours and less operator skill.

The PROSPERITY COMPANY, Inc.

Pioneer Manufacturers of Automatically Controlled and Operated Laundry and Dry Cleaning Machines

Main Office and Factory, Syracuse, N. Y.

Factory Sales, Service and Parts in All Principal Cities


ISN'T THAT PATIENT ENTITLED TO A BED?
1.

NURSE: No-no-no, doctor, you don't understand! That's why I called you. He's been this way ever since breakfast.

PATIENT: Whooee!

RESIDENT: Well, what on earth did he have for breakfast?

NURSE: The house diet . . . toast, coffee, fruit, and cereal . . . just like yesterday, and the day before.

PATIENT: *Oh no it wasn't like yesterday!*—today it was Post Toasties! Same as I get at home. Whooee! And tomorrow maybe it'll be Grape-Nuts, or Post's Bran Flakes, or Grape-Nuts Flakes. Whooee!

RESIDENT: But I don't see what . . .

PATIENT: I wrote notes to the dietitian. Dozens of them. Asked her why I couldn't have the cereals I eat at home, as long as they were on my diet. And today I got them! Whooee!

RESIDENT: Is this cereal-therapy something new?

PATIENT: "T'ain't therapy—it's psychology! I get them at home! *I like them!* They're full of whole-grain "Basic 7" nourishment! So why shouldn't I feel better?

RESIDENT: A path-of-logic, if I ever heard one! Call his doctor about a discharge, Nurse. I'm going to see if the dietitian has some more of those General Foods cereals.

NEWS IN REVIEW

Hospital Needs to Be Met, Says Director of O.C.R.

WASHINGTON, D. C.—The essential needs of civilian hospitals for capital equipment and operating supplies will be met under the Civilian Goods Program, according to a recent assurance to The MODERN HOSPITAL by Arthur Eaton, director of the Office of Civilian Requirements.

On June 21, Donald M. Nelson made public a letter from William Y. Elliott, vice chairman for civilian requirements, together with a list of tables showing quantities of essential goods needed by the civilian economy. The list itemizes the hard goods products, the amounts to be produced in the third quarter and the amounts required at a minimum level, a "squeeze" level and an unrestricted level.

The list shows the principal producers, the materials and manpower required, the labor area involved and similar data. The list is constantly being adjusted in the light of new information.

The most serious shortages are in mechanical refrigerators, vacuum cleaners (domestic and industrial), office machinery, laundry and dry cleaning machinery, washing machines, ironing machines, floor finishing and maintenance machinery, all sorts of refrigeration and air conditioning equipment, bathtubs, plumbing fixture fittings and trim, Class B oil burners, Class B stokers, mop wringers and stainless steel cooking utensils (commercial and domestic).

Army Expandmobile Is Latest Aid to Wounded

A new emergency mobile unit that is capable of expanding from the legal maximum width of 8 feet for moving on highways to 14 feet, 3 inches when used as an operating room is being displayed in the Army Service Forces "Weapons of War" exhibit in New York City.

When used as set up, the "expandmobile" is large enough to enable two surgeons and their helpers to operate simultaneously. Its special equipment includes a built-in tank and pump for water supply, a heater for the water, a basin with running water, operating room lights and ordinary illumination, two operating tables, cots, splint racks and supply cabinets.

The expansion of the unit can be accomplished either manually or by hydraulic motivation. It was designed according to Army specifications by Hub Industries, Inc.

Rehabilitation Program Outlined by Navy

By EVA ADAMS CROSS

WASHINGTON, D. C.—The Navy's rehabilitation program hopes to achieve maximum adjustment of the individual patient either for further military service or for return to civilian life with the least possible handicap from his disability. This was the concise summary offered by the program's director, Capt. Howard H. Montgomery (MC) USN, in an interview July 8.

Rehabilitation, Captain Montgomery pointed out, covers the various activities and services, in addition to the usual therapeutic procedures, necessary to restore to the greatest possible extent physical, mental and vocational efficiency to wounded or ill naval personnel.

Maximum use is made of the time, including the convalescent period, which a patient must spend in a hospital. For those who can return to active duty, training in their particular military assignment is given. For those whose disability warrants a discharge from service, return to civilian life is facilitated through extensive rehabilitation measures and readjustment activities of rehabilitation and civil adjustment officers who inform the veteran of employment opportunities and his rights under existing legislation.

Naval installations specializing in various phases of the rehabilitation program include: Mare Island, Calif., amputation center; Philadelphia, amputation and blind and deaf center; Oakland, Calif., plastic surgery; Chelsea, Mass., neurological surgery; Brooklyn, N. Y., cancer; Bethesda, Md., neurological surgery and tropical medicine; San Diego, Calif., plastic surgery; Corona, Calif., rheumatic fever and tuberculosis; Treasure Island, Calif., tropical diseases.

Hospital Corps Officers Graduated

WASHINGTON, D. C.—Seventy-two hospital corps officers completed a course in hospital administration at the National Naval Medical Center at Bethesda, Md., on July 5. A new class of 75 hospital corps officers has reported to the center for a six months' course in hospital administration. A class of 35 hospital corps officers completed a special course in epidemiology July 17.

Laundry Convention Canceled

In response to the request of O.D.T., the National Association of Institutional Laundry Managers has canceled the convention that was scheduled to be held in Philadelphia on August 25 and 26.

Lanham Act Funds for Nursing Facilities Low

WASHINGTON, D. C. — On June 29 Maj. Gen. Philip B. Fleming, administrator, Federal Works Agency, notified the surgeon general of the U. S. Public Health Service that the funds earmarked for providing nurses' facilities under the Lanham Act Community Facilities Program have been almost entirely exhausted.

Since about one tenth of the earmarked allotment remains unobligated, the regional offices of F.W.A. were instructed to process no more additional applications than the dollar value represented by one tenth of the expenditure for nurses' facilities in the respective region from the beginning of the program in the summer of 1943 through June 29, 1944.

As of June 29, 175 active Lanham projects providing nurses' facilities had been acted upon by the F.W.A. program and projects review board in Washington. These 175 projects will provide a total of 8473 nurses' beds plus training facilities. The total cost of these 175 projects is estimated to be $16,554,753, involving $11,534,102 of federal funds and $5,020,651 of applicants' funds.

Regular Lanham Act funds, however, are still available for hospitals and nurses' homes if the need can be proved to arise from the war effort in the locality or that lack of such facilities might well hinder seriously the war work of the community.

South American Architects Assigned to U.S.P.H.S.

WASHINGTON, D. C. — Arrangements have been completed between the Office of the Coordinator of Inter-American Affairs and the U. S. Public Health Service for the assignment of Latin-American architects to the hospital facilities section, U. S. Public Health Service, for special training in hospital and health center design. The first architect to be assigned under this arrangement will be Señor Javier Rast of Chile.

Señor Rast has been associated with the Cooperative Service at Santiago, Chile, in hospital architecture. Upon his return to Chile, he will be responsible for hospital and health center design and construction throughout that country. His association with the hospital facilities section will be that of a student similar to that of other architects, doctors and professional persons who have come into the United States for training through the program carried on by the Coordinator of Inter-American Affairs.

During his stay in the United States Señor Rast will travel extensively visiting hospitals and health centers and interviewing authorities in the hospital, public health and architectural fields.

Social Security Board Cites Need for Medical Insurance

Under the title "The Need for Medical Care Insurance," the division of health and disability studies of the Social Security Board published late in June a summary of the basic information upon which the board recommended in its eighth annual report the application of insurance to the costs of medical care.

The document has not been submitted to the board for official approval but is for use of the staff and limited circulation to other interested persons. The division of health and disability studies is headed by Barkev S. Sanders and functions under the bureau of research and statistics, of which I. S. Falk is director.

The report summarizes existing data on the barriers to adequate medical care, the needs for medical services and ways of spreading the costs. A special section is devoted to Blue Cross plans which are called the most successful nonindustrial prepayment plans developed in the last ten or fifteen years.

"It is generally recognized that the Blue Cross plans have demonstrated, on the one hand, the relative ease of insuring a substantial fraction of the middle-income groups against hospital costs and, on the other hand, the great difficulty of insuring the low-income groups through voluntary methods. Ordinarily, the plans have failed to insure those who most need this protection—the low-income groups."

In discussing medical society prepayment plans, the memorandum states that "for the most part these plans cover employes only. . . . All medical society plans combine prepayment with individual practice. None combines prepayment with group practice. . . . There are many exceptions and limitations which operate to restrict the services provided and to limit the scope of membership."

In contrast to such plans, the report states that "the private group clinic prepayment plans and plans sponsored by consumer groups usually provide a much more inclusive service than that furnished by medical society plans.

"Voluntary insurance fails of its primary purpose—to give insurance protection to the people who need it most. The final test," states the report, "is not good intention but the size of the coverage and the scope of protection. By these criteria, voluntary insurance against the costs of medical care has been tried and found wanting. Its greatest value has probably been the experience gained in learning how to operate prepayment plans for medical costs."

On the basis of the material included in the survey, a recommendation is made in favor of compulsory federally directed medical and hospital insurance "as an integral part of our social security system." It is further recommended that medical care for the indigent be provided under the same system and that the growth of group medical practice be fostered.

In the bibliography of 56 items attached to the report, no reference is made to any articles, papers or material by hospital or Blue Cross leaders who are opposed to the compulsory insurance principle.

Maritime Hospital Group Forms Exhibitors' Association

Dr. R. J. Collins, medical director of St. John Tuberculosis Hospital, East St. John, N. B., was elected president of the Maritime Hospital Association at the second annual meeting of the group held June 20 to 22 at St. John, N. B. Other new officers are Mrs. H. W. Porter, Kentville, N. S., secretary, and Sister Anna Seton, Halifax, N. S., treasurer.

An exhibitors' association was organized at the convention, of which J. H. Ross, Moncton, N. B., is president.

Another organization formed at this meeting is the Hospital Aid Association, which is composed of the ladies' aids of the three Maritime Provinces. Mrs. Percy N. Woodley of St. John is president.

Preliminary Plans for A.H.A. Meeting Announced

Preliminary plans for the Cleveland convention of the American Hospital Association for the first week in October put the spotlight of attention on postwar planning, public health, rural hospital planning, trustees and public relations. All are subjects for general sessions with no conflicting meetings.

The day-by-day program is as follows: Monday afternoon, postwar planning session; Monday night, president's session; Tuesday morning, public health session; Tuesday afternoon, sections on small hospitals, volunteers, purchasing, public hospitals, medical social service and children's hospitals; Tuesday night, trustee session.

On Wednesday morning the rural hospital planning session is scheduled; Wednesday afternoon will include sections on Blue Cross plans, nursing, outpatient departments, business management, pharmacy and tuberculosis; Wednesday evening will be the United Nations session.

Thursday morning is devoted to public relations. Sections on Thursday afternoon are: dietetic, records librarians, construction and mechanics, medical staff, personnel management and mental hygiene. The usual dinner and dance will take place in the evening. Friday morning is the "Mac and Bob" round table.

Among the nonhospital speakers whose acceptances have been received are Thomas S. Gates, chairman of the Commission on Hospital Care and president of the University of Pennsylvania; Marshall E. Dimock, former assistant deputy administrator of the War Shipping Administration; Herluf V. Olsen, dean of Amos Tuck School of Business Administration, Dartmouth College; Morris Fishbein, M.D., editor, J.A.M.A.; Julius L. Wilson, M.D., president, American Trudeau Society; Robert Bingham, chairman of the board, Cleveland Hospital Council, and president, St. Luke's Hospital, Cleveland; John F. Hunt, Foote, Cone and Belding; Gladys Talbot Edwards, director of education, Farmers Educational and Cooperative Union of America, and Ellen Anderson, director of health education, Farm Foundation.

First Negro Nurse Given Captaincy in A.N.C.

Capt. Mary L. Petty of Chicago, the first Negro to hold the rank of captain in the Army Nurse Corps, will supervise nurses' training at the new basic training center to be established at Fort Huachuca, Ariz.

Captain Petty received her training at Freedmen's Hospital School of Nursing in Washington, D. C. She was commissioned a second lieutenant in the Army Nurse Corps in September 1941.

A release from the National Nursing Council for War Service dated July 12 revealed that Negro nurses will be accepted by the Army Nurse Corps without regard to any quota. Truman K. Gibson Jr., civilian aid to the Secretary of War, wired the National Association of Colored Graduate Nurses that Negro nurses will be used both in this country and abroad and that candidates for the A.N.C. should apply for commissions in the regular way.

Negro nurses now serving with the corps are stationed at Fort Des Moines, Iowa; Fort Huachuca; Tuskegee Army Air Field, Ala.; Fort Bragg, N. C., and Camp Livingston, La. One unit of 15 is serving overseas, having been assigned November 1943 to the Southwest Pacific area under Lt. Birdie E. Brown, graduate of Harlem Hospital School of Nursing.

Asks Payment for Indigent Care

The New Hampshire Hospital Association at its first meeting held in Hanover adopted a motion to request that hospitals be paid for the cost of caring for indigents on the basis of the method already set up for the E.M.I.C. program.

Blue Cross Enrollment Totals 14,760,000

With a total membership of 14,760,000 on July 1 the 77 approved Blue Cross plans in the United States and Canada showed a growth of 1,755,000 for the half year and 961,000 for the second quarter. Each of these figures was the largest in the history of the movement for a comparable period.

Net gains of 25,000 or more enrollment during the second quarter were made by plans as follows: Boston, 121,000; New York City, 109,000; Chicago, 63,000; Detroit, 53,000; New Haven, 38,000 (including a substantial number by consolidation with the other plan in Connecticut); Philadelphia, 38,000; Milwaukee, 33,000; Toronto, 30,000; Newark, 29,000; St. Louis, 27,000, and Cleveland, 26,000.

The plans with more than 500,000 members on July 1 were: New York City, 1,607,000; Detroit, 1,142,000; Boston, 822,000; Cleveland, 801,000; Pittsburgh, 708,000; Chicago, 655,000; Philadelphia, 624,000; Newark, 617,000, and St. Paul, 552,000.

A recent special study by the Hospital Service Plan Commission indicates that at least 500,000 of present Blue Cross members are rural residents, exclusive of those who live in villages and small towns.

The incidence of hospitalization among Blue Cross members during the first half of 1944 was 52.45 per thousand, about 1 per cent greater than in the corresponding period of 1943, but the average length of stay dropped from 7.8 days last year to 7.2 days this year.

Hospital Ships Commissioned; Unit Cars Constructed

WASHINGTON, D. C.—Under the direction of the Transportation Corps, Army Service Forces, 10 new hospital ships in addition to the eight already operating were commissioned in June and 100 new unit hospital cars are under construction, according to an announcement of the War Department July 5.

The hospital ships were converted from former Army transports and are sailing to the invasion coast of France and other foreign battle fields to bring the sick and wounded home. The hospital cars will be ready for service in September. All of the 120 ward cars and ward dressing cars in the Army's possession are being converted to unit cars as quickly as possible.

Authorization of the new cars will facilitate the War Department's plan for progressive evacuation of the wounded to Army hospitals as near to the homes of the patients as is consistent with availability of beds and facilities for specialized treatment.

The 24 vessel mercy fleet, operated under terms of the Hague Convention of 1907, will have a total patient capacity of more than 14,000 of which about 3300 will be for ambulants. The medical department staffs the vessels, including the three Navy-operated ships, with Army medical personnel, including surgeons and officers of the Army Nurse Corps.

Hospital Building Program Scheduled for Cleveland

A $3,000,000 program for the building and equipping of three new hospitals in Cleveland was announced on June 21 with the filing of papers of incorporation for a fund-raising organization to finance the program, the Hospital Campaign Corporation of Cleveland.

New 200 bed hospitals are to be built, according to the program, in Collinwood and Kamm's Corner and a new 100 bed hospital, called the Forest City Hospital, in the south central district of the city. In addition, the removal or expansion of four existing hospitals is involved and certain changes in properties are contemplated.

Included on the planning committee are several leading hospital administrators of Cleveland.

Burlingame Ridicules Attack on Psychiatry

A blistering rebuttal of an attack on psychiatry by Henry C. Link, Ph.D., was released on July 16 by the public education committee of the American Psychiatric Association of which Dr. C. C. Burlingame of Hartford Retreat is chairman. Mr. Link's article appeared in the July issue of *American Mercury* under the title "The Errors of Psychiatry."

The title should have been "My Errors Regarding Psychiatry" or "What I Wish Were True," said Doctor Burlingame. He expressed a hope that "an end will come to articles and statements on psychiatric matters based upon partial knowledge, incorrect knowledge or, as is sometimes the case, upon no knowledge at all."

He termed ridiculous the article's charges that psychiatry is creating, not curing, psychiatric disabilities, that it is giving medical standing "to a process of mental and moral softening the like of which the world has never seen" and that psychiatrists are "responsible for the 1,340,000 rejections at the draft boards."

Denying Mr. Link's suggestion that any man ought to be taken into the Army "because it would do him good," Doctor Burlingame agreed that it might do at least some of them good but doubted the good it would do the armed services. No soldier wants to have an unstable or doubtful individual to the right, to the left, in front or in back of him, he said.

Old Army men remember when military service was thought of as a kind of reform school where the bad boys, the ne'er-do-wells and the town's screwballs and drunks were sent, "but the author of this present article is 25 years out of date because we learned in the last war that while that might be jolly for the civilians, it made things very hard for those trying to build an Army to fight."

Charges Discrimination Keeps Negroes Out of Nursing Field

Although Negroes constitute approximately 10 per cent of the population in the United States, with double the white death rates, Negro public health nurses constitute only 3.5 per cent of the 25,000 public health nurses in the country, according to an article by Estelle Massey Riddle of the National Nursing Council for War Service in the August issue of *Public Health Nursing.*

Discrimination against Negro nurses, evidenced by lower salaries and unequal opportunities for advancement, tends to discourage qualified Negroes from entering the nursing field, she said.

If Surgeon General Parran is right in declaring that "the well-qualified Negro nurse and physician are much more successful in caring for their own people than are the well-qualified and well-intentioned white nurse and physician," then it is high time we prepared more of them to fight the diseases that menace everyone, Mrs. Riddle declared.

Army Provides Medical Kits for American War Prisoners

Specially packaged medical supplies have been devised by the Army Medical Department for shipment to American prisoners under control of the Japanese.

The shipments are prepared in three types of units: a 100 man unit, a hospital unit and a bulk supplies unit. Approximately 126 different drugs are provided and each individual package of the 100 man unit contains a booklet with precise instructions for use of the medicines. The medicines selected are those most useful in treating diseases known to be prevalent in the Far East and for ailments likely to beset persons living under prison camp conditions.

The supplies will be distributed by the International Red Cross and packing cases will be labeled in English and in Japanese.

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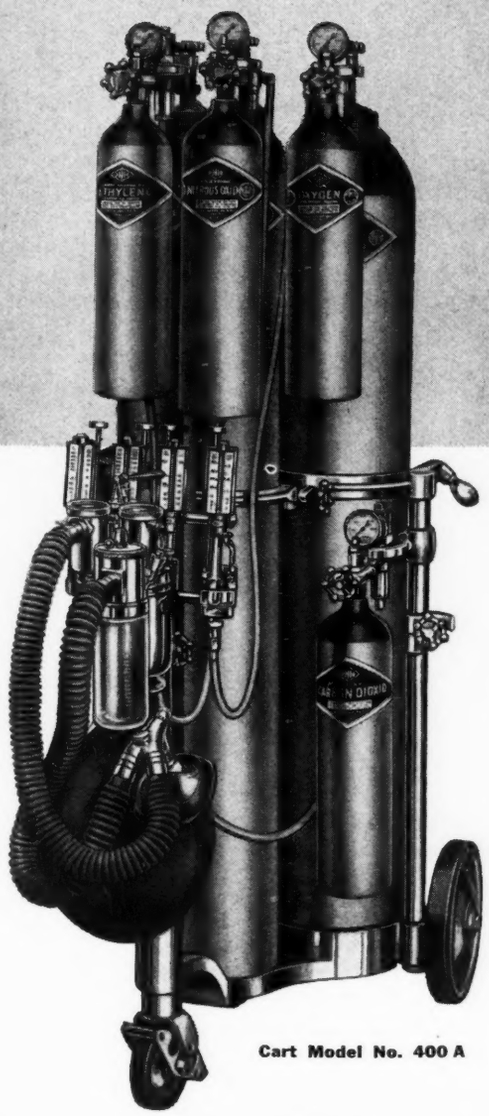

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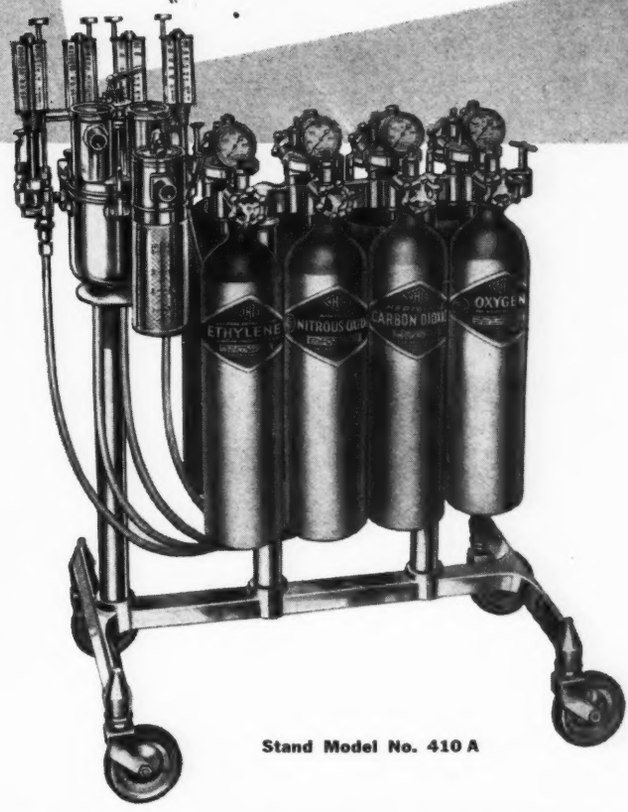

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BRANCHES IN OTHER PRINCIPAL CITIES

ABOUT PEOPLE

(*Continued from Page* 78)

pital, Norfolk, Va. **Dan E. Gay** succeeds Mr. Stull at Phoenixville.

A. G. Schatzman has recently been appointed administrator of Flower Hospital, Toledo, Ohio, succeeding **Rev. R. V. Johnson.**

Dr. L. E. Pennington is the new medical superintendent of Madison State Hospital, North Madison, Ind.

Dr. J. C. O'Neil resigned as superintendent and treasurer of Vermont State Hospital, Waterbury, on July 15. He took the post in 1936 after twenty years of service on the medical staff.

Dr. Go Dek Bing has been elected superintendent of Wiley General Hospital, Kutien, China, as successor to **Dr. Harold N. Brewster,** Methodist minister, who will return to America on furlough. Doctor Go has served at Peiping Union Medical College and the Central Hospital of Nanking and in various government hospitals. He was superintendent of a government hospital near Yungan before accepting the Wiley post.

Department Heads

Effie J. Taylor on July 1 retired as dean of Yale University School of Nursing. **Elizabeth Bixler** of Norwich State Hospital, Norwich, Conn., succeeded her.

Deaths

Dr. Edmund F. Collins, 45, director of Grace Hospital, Detroit, died on June 29 after a brief illness. Doctor Collins was first associated with the hospital as assistant resident physician in 1916 and held several executive positions prior to his appointment as director in 1937. He was also named treasurer of the hospital in 1943. Doctor Collins took a prominent part in medical and hospital activities. He was a fellow of the American College of Hospital Administrators, past president of the Greater Detroit Hospital Council and treasurer and member of the board of trustees of Michigan Hospital Service. **Dr. John H. Law** has been named acting director of Grace Hospital until Doctor Collins' successor is chosen.

L. W. Wheeler, president of the board of directors of Wheeler Hospital Association, Gilroy, Calif., and Mrs. Wheeler were killed in an automobile accident near Stockton, Calif., on June 11. Mr. and Mrs. Wheeler, who were well known for their philanthropic activities, gave the hospital, an auditorium and an athletic field to the city of Gilroy.

Miscellaneous

Dr. Edwin F. Daily, director of the division of health services, Children's Bureau, U. S. Department of Labor, has been granted leave of absence to serve with the Army.

Marian E. Russell has been appointed medical social consultant to the Office of Vocational Rehabilitation, the appointment to become effective on September 1. She will aid in the formulation and development of the medical social aspects of the vocational rehabilitation program, especially as they relate to the physical restoration of disabled persons. Prior to this appointment, Miss Russell was executive secretary of the American Association of Medical Social Workers.

Arthur DeWinter is the new enrollment director of Michigan Hospital Service. He was formerly assistant to **W. H. Lichty** until the latter's advancement to the position of executive director of the plan.

In the May issue of THE MODERN HOSPITAL was a statement that **Dorothy H. McMasters** had recently received a master's degree in hospital administration from the University of Chicago. The registrar of the university has pointed out that this statement is erroneous.

Maine Meeting Covers Trustees, Practical Nursing

Maine hospital people spent two busy days during the last of June in the Women's Union of attractive Colby College, Waterville, considering their many problems. Dr. Frederick T. Hill, Thayer Hospital, Waterville, president of the Maine Hospital Association, was particularly fortunate in bringing together a group of representative people from within and without the state to participate in a program that was divided between small conference groups and general sessions.

The potentialities of practical nursing, the contribution made by professional service audits, the functions of trustees and an analysis of professional journals are to mention just a few of the subjects covered. As a fitting windup to the meeting Dr. Malcolm T. MacEachern conducted one of his round tables.

The program for training the so-called practical nurse or attendant under a vocational plan as outlined by Hilda M. Torrop, executive secretary, Committee for Recruitment and Education of Practical Nurses, prompted the passing of a resolution to the effect that the president appoint a committee to confer with the Maine State Nurses' Association and the Maine Medical Association in studying the situation.

Also, in connection with the nursing problem, a plan of sending student nurses enrolled in larger schools to small hospitals for clinical instruction and training was acted upon favorably. Doctor Hill was authorized to appoint a committee to study this suggestion and to work out an educational program of affiliations between the larger and smaller hospitals.

Among those appearing on the program were Dr. Joseph C. Doane, medical director, Jewish Hospital, Philadelphia; Dr. T. R. Ponton, editor, *Hospital Management;* Dr. Malcolm T. MacEachern; Raymond P. Sloan, editor, The MODERN HOSPITAL, and George Bugbee, executive director, American Hospital Association.

Officers for the new year are: president, Dr. Frederick T. Hill, Thayer Hospital; vice president, L. H. Alline, president, board of trustees, Presque Isle General Hospital, Presque Isle, and secretary-treasurer, Pearl R. Fisher, superintendent, Thayer Hospital.

Sisters Plan New Hospital

A 250 bed hospital and nursing school that will be the "last word" in hospitals is planned by the School Sisters of St. Francis in Milwaukee as soon as wartime building restrictions are lifted. The new hospital will be erected on a 50 acre farm tract and will be the first unit of a large institution that will provide medical care for the city's southwest side.

Alameda Nurses, Hospitals Reach Agreement on Policy

Nine East Bay hospitals and the Alameda County Nurses' Association agreed on a statement of policy concerning salaries, working conditions and personnel practices for staff nurses employed in hospitals, effective on July 1.

The hospitals recognized the executive committee of the staff nurse section of the Alameda County Nurses' Association as the sole employe representative for all such nurses. Entrance salaries of $155 per month, without maintenance, were set with automatic increases of $2.50 per month after each six months until $170 per month is reached.

Two weeks' vacation with pay annually and terminal vacations on request after one year of continuous service; one day of sick leave with pay for each two months of employment during the first two years of employment, and fourteen days noncumulative sick leave thereafter; one whole day off each week, eight hour duty; six recognized holidays per year; overtime of thirty minutes or more to be made up by equivalent time off within thirty days, and provision of Blue Cross protection at the hospital's expense for permanent employes are some of the matters covered.

The nurses are not required to take more than one meal a day in the hospital, the meal to be specified by the nurse, and the charge for one meal shall not exceed $10 per month. The rental of a room is optional with the nurse and the cost must not exceed $10 a month. The hospital may require the nurse to have her laundry done by the hospital but the charge must not exceed $5 per month and must include at least three uniforms a week. Either the nurse or the hospital must give fourteen days' notice of termination of employment.

Nurses who give less than fourteen consecutive working days of service are to be considered staff relief nurses and paid at the prevailing fee for eight hour private duty. Nurses who have worked ninety days are to be considered permanent employes. The standards agreed upon are minimal and may be exceeded by the hospitals.

Seeks to Prevent Rivalry

The Blue Cross plan of St. Louis has adopted a resolution calling upon all other Blue Cross plans to recognize the dangers to the public welfare of uncontrolled rivalry among plans whose boundaries overlap and requesting that immediate steps be taken by the boards of trustees of all approved plans "to check and avoid frictional developments by whatever means are necessary to assure amicable and cooperative relations among all Blue Cross plans and hospitals."

Hospital Librarians to Have Organization

Librarians in hospitals, who up to now have had no special provisions made for their advancement and organization, now have their choice of two such arrangements.

The Special Libraries Association at its recent conference in Philadelphia, June 19 to 21, formed a group for hospital and nursing school librarians. Ruth Tews, head of the hospital library service of the St. Paul Public Library, was appointed chairman. All persons who are interested in receiving the news letter from this group are invited to write Miss Tews.

The group is designed to "give all librarians working in hospitals opportunity for active participation in the national development of their work, in determining standards, in considering publications and in extending their work." Librarians from Chicago, New York, Minneapolis and St. Paul petitioned for this action.

At the same time a petition was circulating among hospital librarians for the formation of a hospital libraries division in the American Library Association. At present, these librarians have only a round table in the A.L.A. A division has almost complete autonomy, elects its own board and officers, has representation on the A.L.A. council and receives for its own uses 20 per cent of the A.L.A. dues of its members.

If a division is formed it would have sections for hospital, institutional, medical and nursing school libraries and for others if needed. The petition was circulated by Mrs. Glyde B. Nielsen, secretary-treasurer, A.L.A. Hospital Libraries Round Table. Mrs. Nielsen is with the Minneapolis Public Library.

Coming Meetings

Sept. 6-9—American Congress of Physical Therapy, Hotel Statler, Cleveland.

Sept. 7-9—American Pharmaceutical Association, Hotel Cleveland, Cleveland.

Sept. 11-22—American College of Hospital Administrators Institute for Hospital Administrators, International House, Chicago.

Sept. 29-30—American Protestant Hospital Association, Hotel Statler, Cleveland.

Oct. 2-6—American Hospital Association, Hotels Statler and Cleveland, Cleveland.

Oct. 3-5—American Public Health Association, Hotel Pennsylvania, New York City.

Oct. 23-27—American College of Surgeons Clinical Congress, Stevens Hotel, Chicago.

Oct. 25-27—American Dietetic Association, Palmer House, Chicago.

Nov. 14-15—Kansas State Hospital Association, Wichita.

1945

March 12-14—New England Hospital Assembly, Hotel Statler, Boston.

April 12-13—Texas Hospital Association, Galveston.

Quotas of Penicillin Increased 20 Per Cent

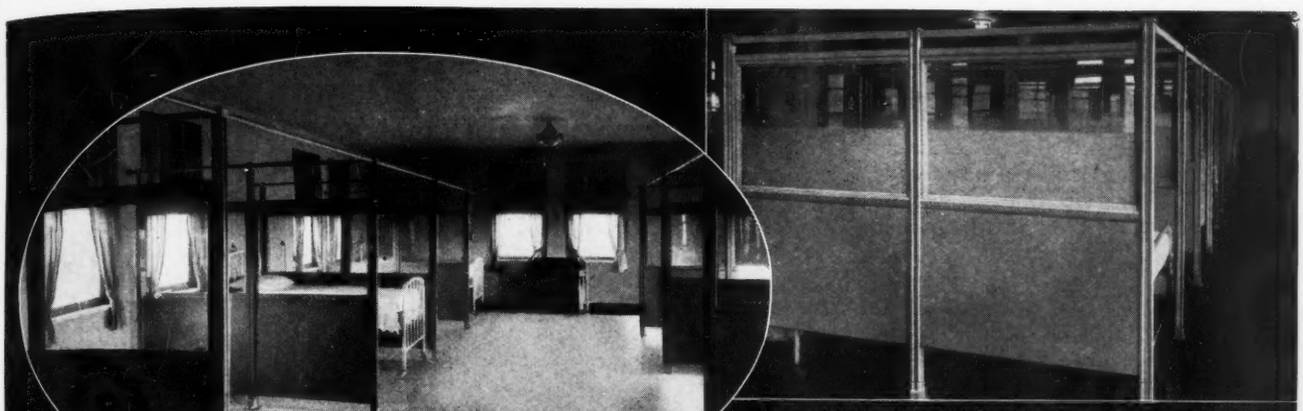
A 20 per cent increase in monthly quotas of penicillin for depot hospitals in the United States has recently been approved.

In line with the original policy of designating additional hospitals as depots with increasing availability of penicillin and the increasing of quotas, the roster has grown from the 1000 hospitals selected in May to more than 2000. The July quota was expected to reach a new high of fifteen billion units which, barring unforeseen emergencies, is to be the regular monthly quota.

Allotments are now beginning to move into the 36 rapid treatment centers to be used for large scale early treatment of syphilis, the U. S. Public Health Service reported on July 14. Some time must elapse before its precise effectiveness in the treatment of syphilis can be determined. It has already proved successful for gonorrhea.

Arrangements for the export of a billion Oxford units of penicillin to other American republics have been completed according to the W.P.B. Plans are under way for restricted world-wide distribution of the drug.

However, less than 1 per cent of our total production has been allocated for use abroad.



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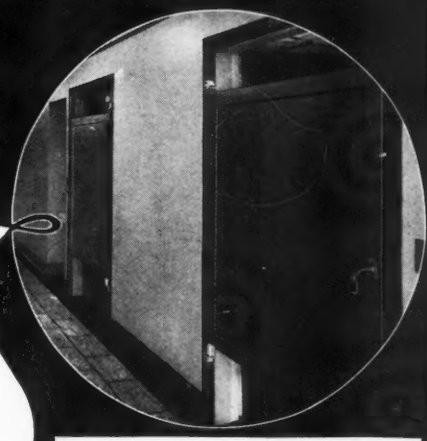

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Canadian Hospital Council Studies Postwar Picture

More hospitals and more beds for the incurable and the chronically ill, for convalescent, mental disease, communicable disease and senile patients and a considerable increase in the number of general hospital beds in Canada are recommended in a section of postwar hospitalization of a recent survey of hospital personnel and facilities made by the Canadian Hospital Council in conjunction with the national health survey sponsored by the Canadian Medical Procurement and Assignment Board.

Although the survey was made in 1943, copies were not printed for release until July 1944.

The report recommends that each province set up a Commission on Hospitalization, representative of the public, the various groups of hospitals and the government. It should draft a long-range plan for hospital expansion for the entire province, sufficiently flexible to allow for unforeseen variations.

The approval of this body should be required for the erection of new hospitals or expansion of existing hospitals beyond a certain number or percentage of beds, the report holds. Voluntary hospitals should be given opportunity to expand equally with municipal or governmental agencies.

In many parts of Canada, states the report, the airplane should prove a valuable means of furthering health care. The airplane could be used not only to bring patients to the hospital, as is now done at frequent intervals, but to carry doctors and nurses to the patient and, in some cases, to bring to the patient a specialist or consultant, sometimes accompanied by his entire surgical team.

"The excellent system of aerial medical service provided in parts of Australia might well be a stimulus to a comparable development in this country. This plan has already been extensively used in many parts of the West in Ontario and Quebec and in certain portions of the Maritimes."

The report also recommends that the hospital become the health center of the community, with doctors' offices, visiting nurses' offices, provincial laboratories and district medical libraries located in the hospital.

Army Nurses Commissioned

WASHINGTON, D. C.—President Roosevelt on July 12 gave a blanket order for the commissioning of all Army nurses as actual Army officers in lieu of the relative rank they have had heretofore. Dietitians and physical therapy personnel in the medical department of the Army also came under the blanket order.

North Carolina Doctors Cooperate With Blue Cross

The North Carolina State Medical Society is actively supporting the local Blue Cross plan in an effort to stave off federal health insurance, according to a statement on June 26 by Dr. Paul F. Whitaker, president.

The state society is urging each county medical society to devote considerable time to promoting Blue Cross enrollment and to place posters urging enrollment in the doctors' offices throughout the state.

Doctor Whitaker also said that the society is backing plans of Gov. J. M. Broughton to establish a number of small hospitals throughout the state to bolster the services now offered. He believes that the cost of caring for the indigent sick should fall on local governments and that each county should make adequate provisions for its own indigents.

"After voluntary hospital insurance plans are promoted intensively for two or three years," he said, "if it is evident that there is a fairly large block of persons unreached by these plans, I would then favor federal and state appropriations to care for these people, the funds for such care to be channeled through the medical profession in the various states."

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Army Doctors Lean Toward Private Group Clinics

A large percentage of the physicians now in the armed services would like to enter private group clinics on their return to civilian life, according to a pilot tabulation of questionnaires sent to them by the American Medical Association.

Fifty-seven per cent of the group licensed between 1937 and 1943 would like such an arrangement and the same percentage was reported for the group licensed between 1930 and 1936.

Among the older physicians, the tendency to group practice is not quite so strong, a report in the June 24 issue of the *J.A.M.A.* indicates.

Doctors wishing to practice on a full-time salary basis constituted 4 per cent of the youngest group, 9 per cent of the next older group, 12 per cent of the next group and 3 per cent of the oldest category.

Apparently the questions were phrased so that the full-time salary basis did not include government service because the percentages wishing to continue in government service, from young to old, were: 5, 10, 17 and 33. Nearly one third of the doctors want to go into general practice, about 55 per cent want full-time specialization and about 13 per cent want to spend part of their time in a specialty.

More than 90 per cent of the youngest group of physicians want some additional medical education, half of them wishing one year or more of training.

Kentucky, North Carolina Hit by Poliomyelitis

Poliomyelitis reached epidemic levels in North Carolina and Kentucky during June, the U. S. Public Health Service reported on July 17. A total of 480 cases was recorded for the month in the entire country, 130 of them in North Carolina and 55 in Kentucky. No other states reported figures above normal expectancy.

Many of the North Carolina cases are being treated at Charlotte Memorial Hospital, Charlotte, where two large Army hospital tents have been erected on the hospital grounds to provide enlarged capacity, according to Carl I. Flath, administrator.

Other emergency hospital facilities have been provided at Lake Hickory Fresh Air Camp and Moore General Hospital, Black Mountain.

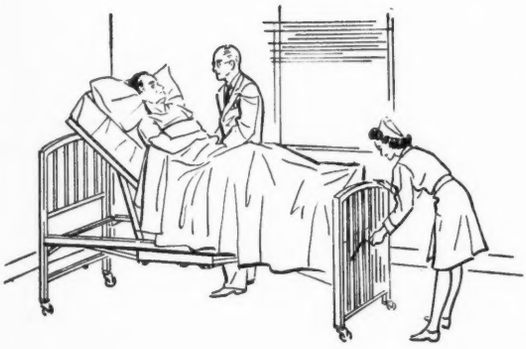
A special grant of $50,000 has been advanced by the National Foundation for Infantile Paralysis for epidemic relief and doctors, nurses and physical therapy technicians have been sent to western North Carolina.

Hospital Decoration Book Issued

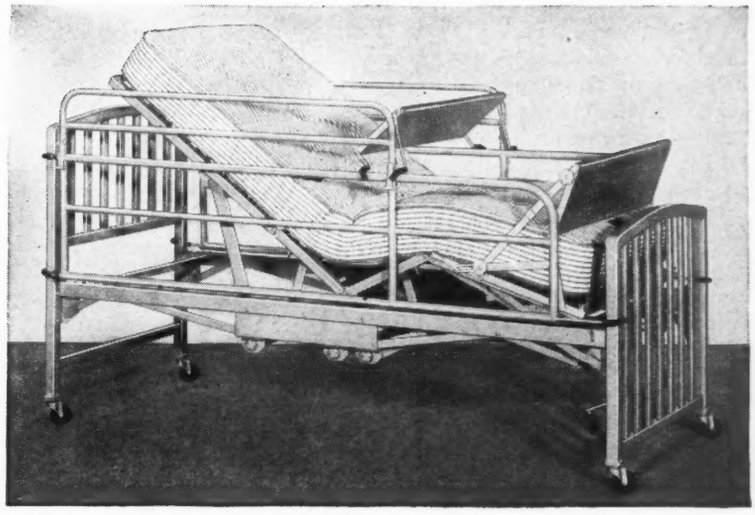
The first book to deal exclusively with interior decoration in hospitals came from the press of the Physicians' Record Company on July 21. It is "Hospital Color and Decoration" by Raymond P. Sloan, editor of The MODERN HOSPITAL. The book has 254 pages plus 16 full-page illustrations. In addition there are floor plans for nearly every department of the hospital and a four page insert of color charts with 60 different colors shown. Introductions are by John N. Hatfield, administrator, Pennsylvania Hospital, Philadelphia, and Faber Birren, color consultant, New York City.

71 Bed Hospital to Open

A 71 bed hospital for private patients of private physicians has been opened at Eloise Hospital and Infirmary, Eloise, Mich. A total of $165,000 of federal and local funds will be used to remodel and reequip Building B for this purpose. The opening is scheduled for September 1. The building is to be leased by the People's Community Hospital for the duration and six months, after which the building reverts to Eloise Hospital and the equipment to the People's Community Hospital, which plans to build a voluntary hospital at Eloise. A recent survey showed the area to be deficient in physicians and general hospital beds.



Designed TO HELP PATIENT..DOCTOR..NURSE



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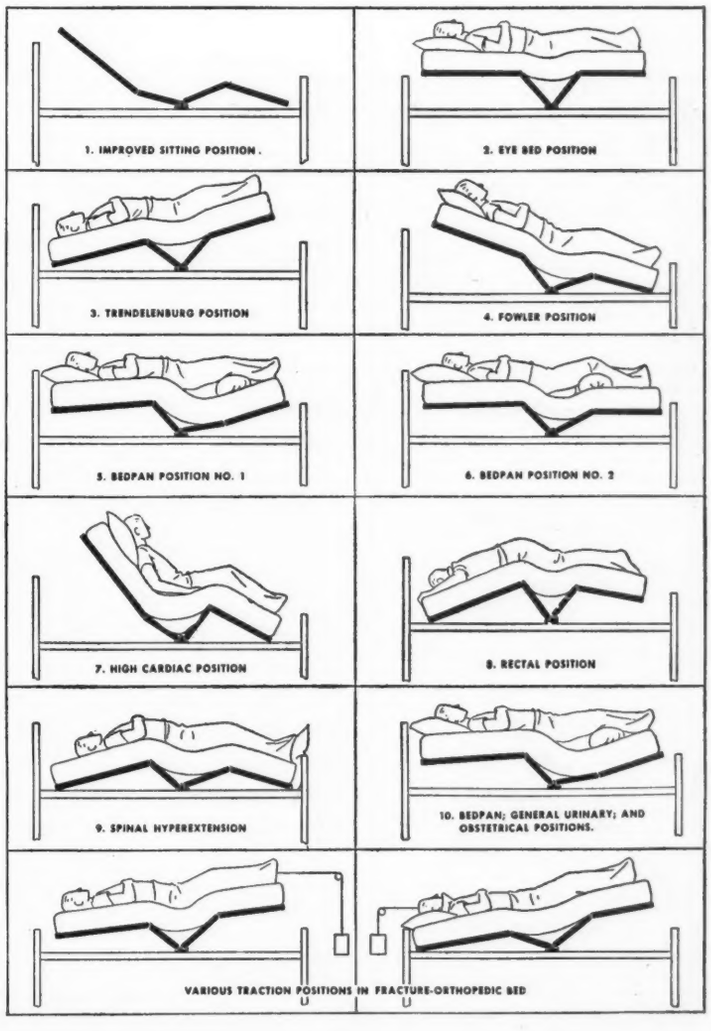
These and many other advantages make the Multi-Position bed an essential part of your equipment. Ask your hospital supply dealer about it today . . . or write us without obligation for full details.



SIMMONS COMPANY
Hospital Division
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New Hampshire Women Aid Blue Cross Plan

In spite of heavy demands upon their time to do farm work, women members of the farm bureau in New Hampshire are enrolling a substantial number of members in the Blue Cross plan.

The county home and community chairman have in nearly every town in the state some woman who is a leader in farm bureau work. These local leaders are instructed in the procedure for setting up Blue Cross groups by Mrs. Louise Stoddard, chairman of the Associated Women of the Farm Bureau. In the last three months, such groups have been established in 15 towns in the state.

The farm bureau has also shown considerable interest in the recently organized Blue Shield, set up by the New Hampshire Medical Society to cover medical and surgical care.

New Wing for Nurses' Home

Another wing will shortly be added to the Mary E. Lambert Nurses' Home of Silver Cross Hospital, Joliet, Ill., to meet war-time demands for the training of more nurses. The new wing, which will cost $160,000, will provide accommodations for 52 nurses. An F.W.A. grant of $110,000 has been made to meet part of the cost of the structure and the remaining $50,000 will be provided by the hospital through private gifts. Construction of the new section is expected to start shortly.

Lawyers Guild Upholds Aims of Wagner Bill

In contrast to the sharp criticism of the Wagner-Murray-Dingell Bill voiced by the American Bar Association, the National Lawyers Guild supports the general aims of the bill although suggesting some modifications of details. This stand is contained in the July issue of the *Lawyers Guild Monthly,* published by the Chicago chapter.

The guild report states that the aims of the bill are on the whole acceptable and are a logical extension of our existing social security laws and should be supported on a bipartisan basis. It refers to medical opposition "by an unusually active pressure group, whose organized campaign against the bill tends to confuse the real issues."

The report contends that the bill would offer a minimum of interference with private medical practice and would actually increase the incomes of most physicians. "In any case, the provision for medical and maternity benefits will serve to promote the public health and welfare and that must be the paramount consideration."

Nurses' Home Formally Opened

Named in honor of the hospital's administrator, the Priscilla Campbell Nurses' Residence of Public General Hospital, Chatham, Ont., was officially opened on June 21. The $60,000 home can accommodate as many as 85 nurses and includes complete educational and work facilities. Many of the furnishings were presented to the hospital by various women's organizations of Kent County.

Army, Navy to Recruit 8500 Nurses

A campaign to recruit at least 8500 nurses for the Army and Navy has been launched by the War Manpower Commission and the American Red Cross. The nurses will be recruited at the rate of 1000 a month for the Army and 500 a month for the Navy. A portion of the required number of nurses will be recruited from the cadet nurse corps.

You May Hire War Prisoners

Nonprofit voluntary hospitals are eligible to employ prisoners of war, the American Hospital Association reported in Bulletin No. 35 from the Washington Service Bureau. Full details regarding the procedures for obtaining, housing, feeding, paying, guarding, transporting and supervising prisoners of war are given in the bulletin.

List of Hypodermic Needles

A new list of hypodermic needles has been recommended to all hospitals as a standard by the A.H.A. committee on purchasing, simplification and standardization. Dr. Malcolm T. MacEachern has approved the list on behalf of the A.C.S. and all manufacturers have assured the committee of their desire to cooperate.

There are 22 needles included on the list. The first 13 are of the regular luer type and are as follows: 26 by ½ inch S.B.; 25 by ⅝ inch R.B.; 24 by ¾ inch S. and R.B.; 22 by 1½ S.B.; 22 by 2; 22 by 3; 20 by 1½ S.B.; 20 by 2; 18 by 2 S.B.; 19 by 3; 15 by 3½; 20 by 4; 20 by 6. Two Quincke spinals with stylette needles are included: 20 by 3½ and 22 by 2. One Pitkin spinal with stylette of 22 by 3 is recommended. One spinal with stylette 19 by 3½ is added. A regular curved tonsil needle and regular straight tonsil needle are listed. The last three are hose hub needles, 15 by 2, 17 by 2 and 18 by 2.

President Upholds Deferment Ban

In response to a request to review the Selective Service order banning occupational draft deferments for premedical students, President Roosevelt on July 4 refused to intervene. He pointed out that the Interagency Committee on Deferments had concluded that present day medical students would not be available to practice medicine before 1948 and that "many of them would never study medicine."

Public Will Benefit by Army's Measles Serum

Civilians will soon benefit by gamma globulin, which has been shown by the Army to be of great value in halting measles epidemics. Under agreements already drawn up, the Navy will have control of the serum, which is a by-product of the preparation for medical use of blood donated to the Red Cross, and will take first what is necessary for the Army and Navy. Surpluses will then be released to the Red Cross, the U. S. Public Health Service or other governmental agencies and to state and local health departments whose orders are approved by the Red Cross.

Hospitals may obtain the material from state and local health officials. It will be supplied for the cost of processing; resale or profit-taking of any sort is forbidden.

The commission on measles and mumps of the Army's preventive medicine service found that the gamma globulin would halt an epidemic of measles if it was given to all persons who have been exposed as soon as the first few cases appeared.

Minnesota Favors Hospital Building

A recent survey of public opinion by the Minneapolis *Star-Journal* and *Tribune* revealed that 19 per cent of Minnesotans say that hospitals are the most important postwar public building programs. Only one other category, highways, with 29 per cent, exceeded the hospitals in popularity. Other preferences were airports, 13 per cent; schools, 11 per cent; slum clearance, 7 per cent; public buildings, 6 per cent, and others and "don't know," 8 per cent.

Thirty-six per cent of those interviewed prefer public building programs supported by federal, state and community governments as the best way to fight postwar unemployment; 38 per cent favor government financial aid to help business and industry, and 15 per cent favor unemployment allowances.

Folder "Sells" Fund Drive

An illustrated folder, "When It's Our Own," is being mailed to thousands of families in Essex County, New Jersey, to explain the need of Presbyterian Hospital, Newark, for $700,000 to complete its building fund. The publication pictures the scope of the hospital's program, which includes construction of a modern nurses' school and residence and expansion of the x-ray, laboratory and physical therapy departments of the hospital.

Department of Health Closes Chicago Hospital

Chicago health department authorities on July 18 closed the 65 bed, nonapproved People's Hospital, in which a strange traffic in illegitimate babies had been revealed. Dr. Herman N. Bundesen, president of the board of health, ordered the hospital closed because of insanitary conditions and the keeping of faulty records in connection with births of babies to unwed mothers in the institution.

Action was taken following the filing of a suit in the County Court by Angeline Kolodziej, who sought to recover her son, born on June 15 at the hospital, and given in adoption to a Detroit family.

The 50 patients who were in the hospital at the time of the closing order were permitted to remain until they were able to go to their homes, but no new patients were admitted. Dr. Dante Cortesi is superintendent of the hospital.

Hospital Care in Australia

Hospital service up to the level provided by the public hospitals would be provided to everyone in Australia without charge, if the desires of the Joint Committee on Social Security are carried out. In its seventh interim report the committee recommends that those persons desiring semiprivate or private hospital accommodations should be given an allowance toward the cost which would equal the value of ward services. It also recommends that approved standards of hospital care be established so that all taxpayers would receive an equal benefit. An alternative proposal is for the Commonwealth to pay a flat subsidy per occupied bed.

70 Per Cent of Russian Wounded Back in Service

Hospitals of the Red Army Medical Administration and of the People's Commissariat of Health Protection have returned more than 70 per cent of all Russian wounded men to active service, the People's Commissar of Health Protection stated in a speech at the tenth session of the Supreme Soviet of the U.S.S.R., it is reported in the *Bulletin of the U. S. Army Medical Department* for May. This percentage has remained constant throughout the war.

The mortality in hospitals is much lower than that of the first World War, and in hospitals of the People's Commissariat it is a little more than 1 per cent. Whereas more than 60 per cent of those with wounds of the extremities during the first World War had to undergo amputations, the number of amputations in the present war has been reduced to one third. The mortality among patients with chest, spine, face and jaw wounds has been reduced from three to four times.

Course for Practical Nurses

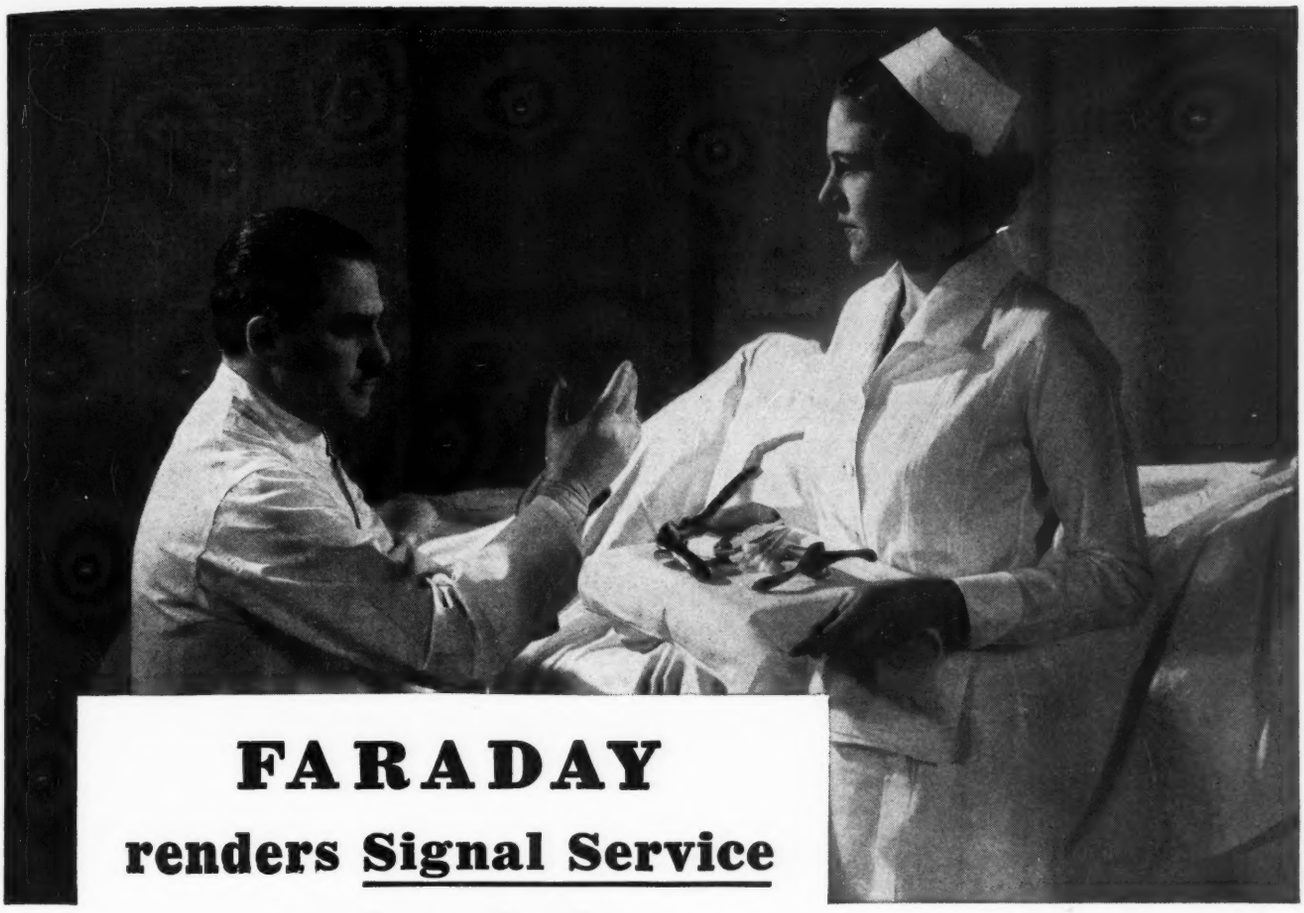
Plans for a course in practical nursing to start September 1 have been announced by Montefiore Hospital, New York City. The course is open to both men and women who are American citizens and who have had at least elementary school education. Tuition, books, uniforms and maintenance are free. The course consists of two months of classroom instruction and seven months of practical ward service. Anne Donahue, superintendent of nurses, is in charge of registration.

Hospital Receives $1,000,000

One half of the residuary estate of the late Norman L. Noteman, estimated at more than $2,000,000, has been left in trust for the New Rochelle Hospital, New Rochelle, N. Y. Mr. Noteman's will directed that the trustee of the estate establish the "Noteman Memorial Fund," the income to be used for the general purposes of the hospital, and authorized the use of the principal for the construction of new buildings.

With Wartime Personnel Shortage

Emergency signals gain new importance!



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OFFICIAL ORDERS
June 15 to July 15

Automobiles.—Since July 10 all 1942 hard-top cars with a factory list price of between $1500 and $2500 and also 1942 convertible soft-top cars with a list price up to $2500 have been rationed on the same basis as the popular lower-priced hard-top auto. Liberal requirements have been revoked to conserve the remaining small supply of cars for persons whose needs are considered essential. Applicants for all rationed passenger cars with a list price under $2500 must show they need an automobile principally for one or more listed occupations essential to the war effort or to the public welfare, such as doctors, ministers and war workers.

Bathtubs.—Production of 50,000 bathtubs made of cast iron in the third quarter of 1944 has been provided for limited distribution, W.P.B. reported June 24. The sale of these tubs will be limited but construction projects authorized by preference ratings regularly assigned to war housing and other construction projects for which tubs are essential, such as hospitals and institutions, will be permitted delivery on these items.

Civilian Goods.—Preferential treatment for 124 items for civilian output was accorded by W.P.B. on July 13. Items in the list of interest to hospitals include: cooking and heating appliances; cooking utensils; commercial food preparation and serving fixtures, equipment and appliances; kitchen utensils; office machinery; photographic equipment and accessories; plumbing fixture fittings and trim and sanitary ware. These are general categories and specific items will replace them later.

Specific items already on the preferred list are: ash cans, cast iron and steel boilers, diaper cans and pails, flatware and hollowware, electric fans, floor finishing and maintenance machinery, garbage cans, unit heaters and ventilators, electric and gasoline flatirons, commercial laundry machinery, marking devices, innerspring mattresses, motion picture projection equipment, laboratory scales and balances, domestic sewing machines, stokers, carpet sweepers, hot water storage tanks, typewriters, domestic and industrial vacuum cleaners, water heaters of all types.

Construction. — Applicants normally using WPB-617 to obtain permission under L-41 to acquire or construct facilities were advised by W.P.B. June 24 to follow the revised instructions for the filing of the form. All W.P.B. applications, except those specifically indicated for filing elsewhere, are now to be filed with the local W.P.B. field office. Applications for certificates of necessity where tax amortization privileges are requested, which are filed simultaneously with WPB-617 applications, will likewise be filed with the local office rather than with W.P.B. in Washington, D. C., as heretofore.

W. S. Brines of the hospital section, W.P.B., called particular attention, however, to the fact that hospital projects costing $25,000 and up will still be **processed** in Washington. The field offices will "screen" and act in an advisory capacity to applicants but the application will be forwarded to Washington for analysis and final decision. Any hospital, repeated Mr. Brines, wishing an informal decision may answer the questions on WPB-617.1 (or WPB-2814.1) and send answers and request to the hospital section, W.P.B., where the case will be studied and an informal reply given.

Applications involving grants of federal funds continue to be filed with W.P.B. in Washington.

Cooking Equipment.—Amendments to orders L-182 and L-248 permit production beginning July 1 of nonelectric commercial cooking and plate-warming equipment at a rate of 72 per cent of 1941 production and nonelectric commercial dishwashers at 92 per cent. The increase is planned primarily for industrial feeding purposes.

Fire Protective, Signal and Alarm Equipment.—Restrictions on the distribution of this equipment were relaxed on July 13 by W.P.B. The amendment permits the use of copper and copper base alloys for specified parts of such equipment, chief among which are hose line fittings and fire hose couplings in sizes other than 1½ and 2½ inches.

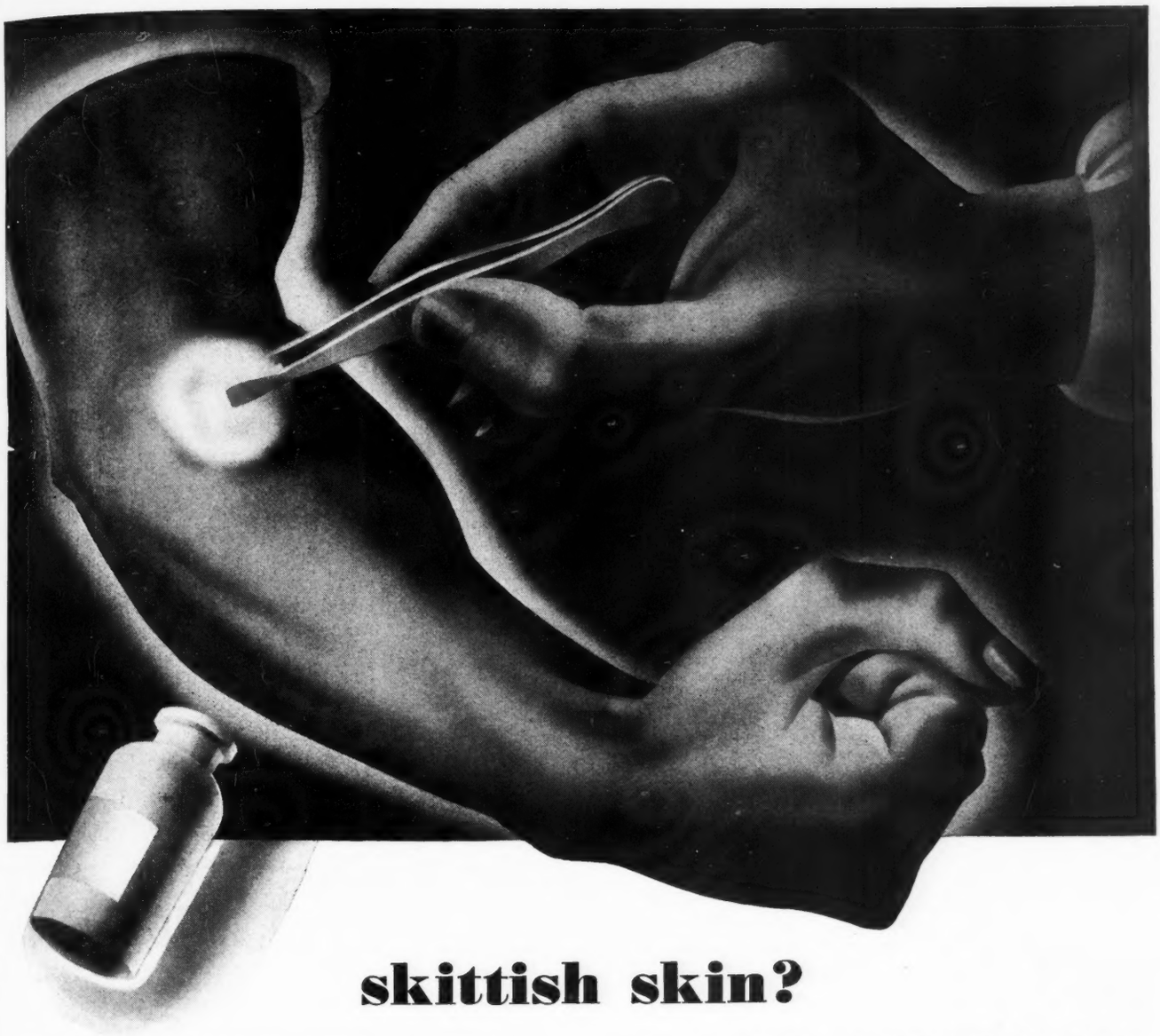
Fuel.—Supplies of coal, fuel oil and wood will remain tight through 1944 and into 1945, O.W.I. stated on July 17. A deficit of 21,000,000 tons of coal was estimated for the year beginning April 1, 1944.

Galvanized and Aluminum Ware.—There will be more iron and steel for galvanized ware with no restrictions on the types of iron and steel used in its production and a greater variety of sizes permitted because of an amendment June 21 to L-30-a. Among classes of galvanized ware items that may be manufactured for civilians are: garbage and ash cans and pails (including inserts for step-on cans); pails, buckets and tubs; washtubs; wash boilers; storage cans for petroleum products; fire shovels; funnels; coal hods and scuttles.

Heating Equipment—The recent amendment to W.P.B. construction order, L-41, providing for the installation of heating and combustion control equipment within certain cost limits without W.P.B. approval was not intended to change restrictions on the purchase and installation of new heating equipment, such as boilers and furnaces, the Plumbing and Heating Division, W.P.B., explained July 1. Order L-79, governing plumbing and heating equipment, requires specific authorization for the purchase of stokers with a capacity in excess of 60 pounds per hour, domestic types of oil burners, extended surface heating equipment, furnaces, boilers, water heaters, range boilers and cast iron tubular radiators. The requirement has not been changed by the amendment to L-41.

Equipment that has been released for unrestricted sale, including thermostats, barometric regulators and limit controls, is included under the provisions of the amended construction order.

Lighting Equipment.—Any relaxation in the use of copper for lighting fixtures will be made only when the quantities involved are small and when the war effort is impeded by restrictions, W.P.B. announced July 3. Aluminum will probably soon be permitted for many lighting fixture items formerly made from copper or brass.



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Partner in Medical Progress

Penicillin.—Considerable variation in the maximum price of penicillin exists at present, O.P.A. stated on June 23. During the initial production period costs of manufacture varied widely and O.P.A. recognized this fact in establishing maximum prices. Actual selling prices have declined markedly during the past year. One seller's price to civilian hospitals is $3.15 per 100,000 Oxford units but it sells to the government at a much lower price.

Plumbing Fixtures.—In the clarification of Schedule V of L-42, Plumbing and Heating Equipment, June 23, concerning the limitations on the use of metals in plumbing fixture fittings and trim, the schedule was also amended to extend the exceptions to the restrictions on the use of metals for plumbing fixture fittings and trim to include all buildings that comprise a hospital group instead of just the main hospital building. A "hospital group," according to an official of the hospital section, W.P.B., includes such buildings as laundry, power or boiler house, doctors' or interns' homes, in fact, any building that is part of a hospital or operation of a hospital.

Limitations on the use of metals in plumbing fixture fittings and trim apply to the assembly and finishing of such equipment as well as to the manufacture, the reworded Schedule V makes clear. The previous wording had been erroneously interpreted to permit the use of metals for plating and finishing by persons other than the manufacturer of the equipment. All buildings in a hospital group, clinics and dispensaries are among the general exceptions listed.

Refrigerators.—Domestic ice refrigerator production quotas total 128,175 units for the third quarter of 1944 and have been assigned to 21 manufacturers, W.P.B. announced July 1. Mechanical refrigerators, especially in the domestic sizes, are still scarce.

Sugar for Canning.—Revised allowances of sugar to institutional users for use in home canning, jams, jellies, preserves, marmalades and fruit butters were announced July 10. No sugar may be used to can an item which has a zero point value. The new allotments which became effective July 14 are: for **jams, preserves and marmalades,** 1 pound of sugar for each pound of prepared fruit used in their making; for **jellies,** 1 pound of sugar for each 2 pounds of prepared fruit pulp used in their making; for **home canning** of fruits and fruit products, other than those enumerated, 1 pound of sugar for each 4 quarts or 8 pounds of finished fruit. Some change has been made also in the number of blue points institutional users who engage in home canning shall surrender for home-canned processed foods of all kinds.

Surgical, Dental and Optical Instruments.—Manufacturers of these instruments may now apply for individual adjustments in their maximum prices, O.P.A. announced on July 14, because local shortages of these instruments exist.

Visitors' Meals.—The new national restaurant regulation, effective July 31, exempts certain types of eating places, such as hospitals and other institutions. Hospitals are exempt except for food items and meals served to persons other than the patients if a separate charge is made for such meals and food items. The regulation extends to a country-wide basis the present freeze of restaurant prices at the April 4-10, 1943, level now in effect in most parts of the country.

Water Heaters.—Limited production of electric water heaters for civilian use, new quotas for production of nonelectric water heaters and elimination of restrictions on manufacture or fabrication of metal jackets for water heaters were made possible through changes made July 4 in L-185. Paperboard jackets have proved unsatisfactory and paper is a critical item. Metal jackets will now be made from allotted materials or from aluminum which is specifically authorized for jackets by W.P.B. under the aluminum order.

W.P.B. Instructions.—The next issue of the WPB-1319 instruction pamphlet will be for August-September and the printing date will be July 15. A September supplement will be issued not later than September 1 with a printing date of August 15. Subsequent pamphlets and supplements will have a printing date of the fifteenth of the month preceding issuance.

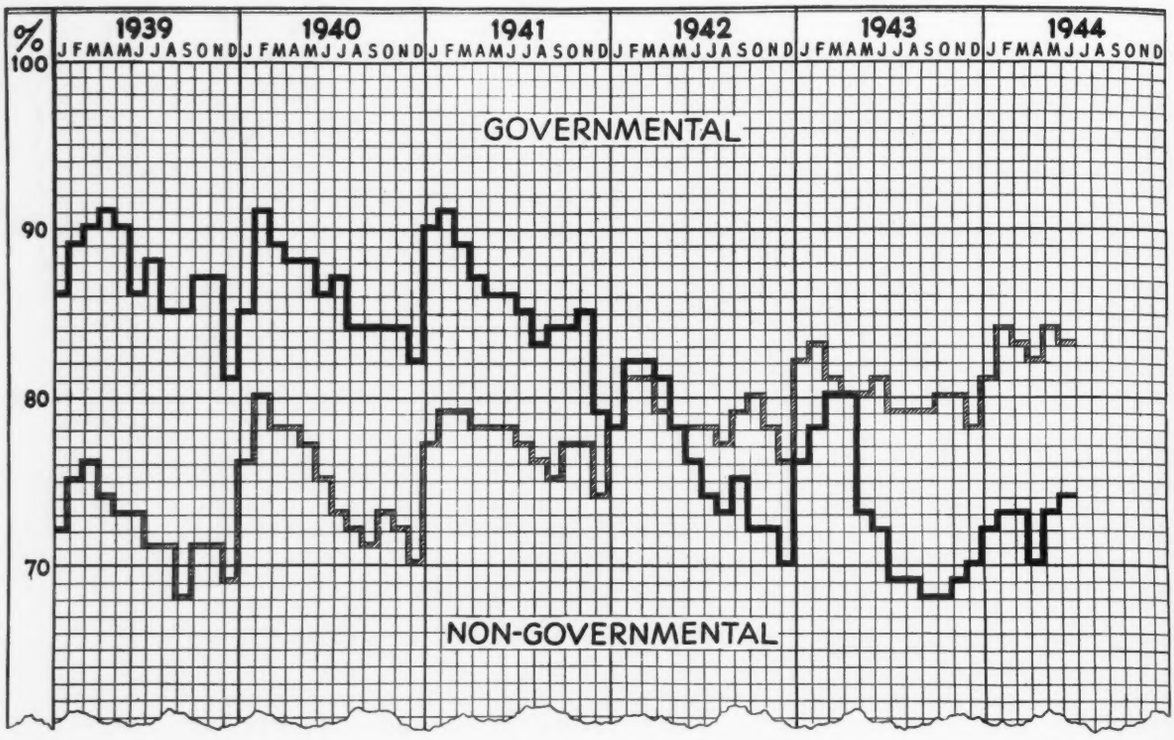
Goldwater Bibliography Issued

A bibliography of the published writings of Dr. S. S. Goldwater was published in June by the Bacon Library of the A.H.A. The bibliography is arranged chronologically and requires 15 pages of mimeographed material. It starts with an article on "Abscess of the Liver" which appeared in *Medical News* for Jan. 18, 1902. Hospital articles have appeared in the *National Hospital Record,* A.H.A. *Transactions, Survey, Trained Nurse and Hospital Review, International Hospital Record,* The MODERN HOSPITAL and other medical, nursing and architectural magazines.

Study Medical Education

A nation-wide study of postwar medical education, designed to develop plans for training future physicians, establish adequate premedical standards and provide educational opportunities for returning medical officers, has been undertaken under the sponsorship of the Advisory Council on Medical Education, according to an announcement by Dr. Willard C. Rappleye, dean of the faculty of medicine, Columbia University, and chairman of the council. A preliminary report is expected in the fall. The council includes representatives of 13 organizations, including the American Hospital Association.

85 Per Cent Is Highest June Occupancy



A slight rise in the preliminary occupancy figures in voluntary general hospitals kept the figures at the high level of 85 per cent for June, the highest June figures ever reported for these hospitals. Occupancy in the governmental group also showed a sharp advance in May and June.

Sixty-six new hospital construction projects were reported from June 12 to July 24. Approximately one half of these were for new hospitals or allied institutions. The total for the year to date is $61,127,000 compared with a net of $63,640,000 last year.